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Toronto School Drug Survey

In January of 1968 a research group commissioned by the Addiction Research Foundation of Ontario began a five-month survey of drug use among students in Metropolitan Toronto schools. The survey was planned by a committee of the Foundation's research staff, headed by Dr. Reginald D. Smart. The data were collected and analysed by the Toronto firm of David Jackson and Associates. The purpose of the survey was to determine:

- the extent of use of various drugs—including hallucinogens, psychoactive drugs, solvents, tobacco and alcohol—among students of elementary and high schools;
- the students' attitudes towards the drugs; and
- the differences in use and attitudes among various age and social groups.

This is the largest and most comprehensive survey about

This article was prepared by Milan Korcok, Information Officer, and Dianne Jones, Research Assistant, both of the Addiction Research Foundation of Ontario. The report on which it is based is entitled *A Preliminary Report on the Attitudes and Behaviour of Toronto Students in Relation to Drugs*, and is available at \$3.00 a copy from the Research Division, Addiction Research Foundation, 344 Bloor Street West, Toronto 4.

drugs ever attempted for this age-group. At present, the report of this survey is preliminary; many more analyses are needed.

Twenty-one districts sampled

The survey included twenty-one out of 112 school districts, representing all six boroughs in Metropolitan Toronto and including separate schools but excluding private non-Catholic schools. Districts were chosen at random except in the City of Toronto where special schools were so numerous that it was necessary to make a random selection from all classes. The sample included students from Grades VII, IX, XI and XIII; it was assumed that students below Grade VII would have very little experience with these substances. Parental permission was sought for students' participation in the survey. There was no direct involvement by either teachers or School Board members, and therefore the Foundation takes full responsibility for the survey.

Initially, discussions were held with groups of six or eight girls or boys, chosen either by class vote or at random. The groups met with university students who had been specially trained as discussion-group leaders. The discussions provided an estimate of prevalence of drug use and information concerning the general knowledge of students about drugs, and also enabled the research group to construct a questionnaire. This forty-minute questionnaire was administered to 6,447 students in selected classes.

Methods of estimation agreed

Generally, two approaches were used to arrive at the reported results: self-report, and estimation by the class representatives in the discussion groups. There was good agreement between these methods of estimation so far as marijuana use was concerned; this allowed considerable confidence to be placed in the survey as a reliable and valid study of self-report and other report data. However, the

results are based on students' replies to questions, and little effort has yet been made to confirm the reported drug use by other means.

Of the 6,447 students surveyed, 46.3% reported using alcohol at least once in the preceding six months, 37.6% smoked at least one cigarette per week, 9.5% used tranquilizers at least once in the last six months, 7.3% used stimulants, 6.7% used marijuana, 5.7% used glue, 3.3% used barbiturates, 2.6% used LSD, 2% used other hallucinogens, and 1.9% used opiates (heroin, morphine, codeine).

It is clear that in terms of numbers of users, alcohol and tobacco are still the most important drugs. Users of all other drugs are very much in the minority. It should be noted that the figures are for prevalence of use, and do not differentiate between illegal use and prescription or hospital administration. This latter condition would apply to tranquilizers, barbiturates, stimulants and opiates.

Use in Grade VII low

All drugs were used less often in Grade VII than in the other grades. Only the use of glue was relatively high in Grade VII, but the peak was still at Grade IX. Thus all drug use rates would be considerably higher if Grade VII rates were excluded and the survey was concerned only with the high-school grades.

The peak year for the use of marijuana, stimulants, glue, opiates, LSD and other hallucinogens was Grade IX. For example, marijuana use went as high as 10.8% in Grade IX and glue use as high as 9.4%. Barbiturate and tobacco use increased sharply from Grade VII to Grade IX, peaked at Grade XI and showed a small decline to Grade XIII. Alcohol and tranquilizers were the only drug whose use showed a steady increase from Grade VII to Grade XIII.

Most of the students who had taken these drugs had done so very infrequently. There were few who fell into the maximal frequency-of-use category for any of the drugs (for

Incidence of Drug Use by Grade

Grade	Percentage of Students Using Drug at least Once in Six Months Surveyed									
	Tobacco	Alcohol	Marijuana	Glue	Barbi- turates	Opiates	Stimu- lants	Tranquil- lizers	LSD	Other
VII	24.6	22.9	2.6	7.2	1.3	1.1	4.3	4.8	1.1	1.0
IX	44.3	41.6	10.8	9.4	3.9	3.0	9.4	11.4	3.9	3.1
XI	46.6	59.7	8.9	2.6	4.4	1.8	7.8	11.6	2.1	1.9
XIII	39.7	70.9	7.5	0.7	3.8	1.0	5.6	14.6	3.8	0.9

most drugs this was seven or more times in the last six months). Three to five times more students had taken alcohol, tranquillizers, stimulants, glue, other hallucinogens and opiates only once or twice than had taken them seven or more times. About twice as many students had taken marijuana, LSD and barbiturates once or twice as had taken them seven or more times. The only exception was tobacco where about the same number had used it one to five times (14.9%) as had used it twenty times (14.5%) per week. It would appear, then, that a large part of student drug use is experimentation.

For all drugs but tranquillizers there was a larger proportion of male users than female users. The sex differences were large for marijuana, LSD, and glue. Marijuana had been used by 8.6% of the boys and 4% of the girls, LSD by 3.4% of the boys and 1.2% of the girls, and glue by 7.4% of the boys and 4.2% of the girls. Differences were much smaller for tobacco and alcohol. Tranquillizers were the exception: 10.4% of the girls had used them, compared to 8.1% of the boys.

High grades, low drug use

A number of behavioral and demographic factors were found to be associated with drug use. In the schools, for instance, drug use among those who had achieved A grades was low; but it was disproportionately high among those with failing D or E grades. Of all the students reporting grades of 75% or better, only 6.7% were users of drugs (marijuana and LSD) while 78.8% of those getting A grades were non-users. Similarly, students who used drugs participated less frequently in extra-curricular activities than non-users.

Ethnic origin and religion were important factors differentiating users from non-users. There was more drug use among students whose parents came from the British Isles than among those whose parents came from other areas.

Students who reported that the language most often used in their homes was Italian, Portuguese, or Spanish were less frequently drug users.

Low use among RCs

Among the religious groups, Roman Catholics had the lowest incidence of use: 7% had used drugs and 75.4% said that they would not use them. Of the Protestants, 8.9% had used drugs and 73.8% said they would not use them. Use among Jewish students was highest: 14.6% had used drugs and 63.9% said that they would not. However, the highest incidence of use among the students occurred among those who said that they had no religion or did not know what it was: 18.9% of these students had used drugs and only 57.6% said that they would not use them.

Family relationships and parental attitudes towards tobacco, alcohol and tranquillizers were also related to the way students approached drugs. There was more drug use among students who were not living with their parents, or were living with only one of their parents, than among those from intact homes. Those students who said they would not use drugs generally had parents who used neither alcohol nor tobacco. There was also an association between use of glue and marijuana by brothers or sisters of the respondents and use of drugs by the respondents themselves.

Peer group important

The peer group played an important role in structuring attitudes and behavior. The data showed that 23.7% of all students cited friends as their most reliable source of information about drugs. Of those who smoked, 19.7% obtained their cigarettes from friends, while 51.5% of those using alcohol supplied themselves this way. The harder the drug was to obtain, the more important was the peer group as a source. Evidence of peer-group pressure towards drug use was found in student comments such as: "You see young

guys walking about, sniffing glue, taking marijuana. They're just trying to be big shots. It makes you think that you would like to try it."

Many students felt strongly that the schools had failed in their approach to drugs. Only 10.08% thought that the schools and churches had contributed significantly to their knowledge about drugs. "The school doesn't tell us enough to be able to make any kind of decision about drugs or alcohol. A course couldn't be factual or straight because the teacher is so opinionated. Teachers are afraid of us going and saying bad things to our parents." But at the same time, more than 84% of the students felt that drug education should begin at or before Grade IX.

Summarizing this disappointment with the schools, the home and the public media, one student said: "I don't think adults realize that we know more than they think. If you come out with something about drugs or alcohol or anything at home, they *look* at you. That's half the trouble: they push it away and say it's dirty, so the kids turn around and find out from their friends or try it themselves." The lack of communication between educational institutions and students and, more important, between parents and children may make it difficult to modify the behavior of drug users.

— M. K., D. J.

[On rapporte les premiers résultats d'une enquête sur l'usage des drogues et sur l'attitude envers l'usage des drogues parmi les étudiants d'écoles élémentaires et secondaires, dans la municipalité du Toronto métropolitain. Les données faisant l'objet de l'enquête comprenaient des rapports d'étudiants qui avaient fait usage de drogues et des estimations, faites par des étudiants, quant à l'usage des drogues parmi leurs compagnons de classe. Ces deux méthodes d'enquête ont donné sensiblement les mêmes résultats. On a découvert que l'alcool et le tabac sont les deux drogues les plus utilisées; que les usagers de toutes les autres drogues ne constituent qu'une petite minorité.]

A Drug Abuse Program At a State Mental Hospital

By Wayne M. Wilson, M.S.W.

In California, as in many other areas, the misuse of drugs by young people has become one of our major social problems—and has found parents, teachers, law-enforcement officers, and health and welfare agencies ill-equipped to deal with it. In northern California, certain metropolitan districts—such as the Tenderloin and Haight-Ashbury districts of San Francisco—have long been known as drug-oriented enclaves; but recently the suburbs and even the rural areas have also become aware of children in junior and senior high school sniffing glue, inhaling Freon gas, smoking marijuana and taking LSD and amphetamines. Injection of methamphetamine is showing an alarming increase, and there are instances of heroin addiction. Juvenile drug use is a clandestine activity—hidden from adults, who only find out about it after a major problem has developed. Estimates of the proportion of young people involved range from 20 per cent in some communities to 70 per cent in others, and bewildered parents and teachers are searching for ways to “reach” their children.

It was about three years ago that alcoholism agency personnel in San Francisco identified the new patterns of drug abuse in young people as a growing problem. For the first year, special concern was focused on an alarming increase in heroin addiction among late teenagers and young adults. Cases were discovered such as that of a 19-year-old college girl who had a hundred or more LSD trips, which resulted in a series of freakouts, and who was turned on to heroin as a way of recapturing a “beautiful experience.” In

Mr. Wilson is Director of the Alcoholism and Drug Abuse Programs at Mendocino State Hospital, Talmage, California.

a few months of heroin use, she acquired a \$100-a-day habit.

Later, amphetamines became the drug of choice for many, and agencies began to encounter the "meth freak." As long as users took their stimulants orally, the deterioration of their functioning was gradual; but when they started injecting them they became overpoweringly caught up in a drug-using existence. The problem spread rapidly to the suburbs and rural communities, and a further target group for treatment was identified. An example was the 18-year-old boy whose involvement with the drug scene caused him to drop out of his middle-class environment. After several months of shooting methamphetamine he became less and less able to shake his paranoia and hallucinations—even with barbiturates to bring him down. The residual paranoia he acquired from his drug experiences accentuated the fears that go with the furtive "dope fiend" life he was leading; in a panic, he appeared at the San Francisco General Hospital asking for a place to hide.

Residential care needed

In 1967, the San Francisco General Hospital alone saw almost four thousand young people with drug problems. Agency personnel began to feel that many of these patients needed to be removed from an area that was perpetuating their drug dependence; many of them also needed residential psychiatric care, as they were showing episodic psychotic symptoms that were likely to persist for months.

The long-standing involvement of Mendocino State Hospital in community mental health enabled it to respond as a major therapeutic resource, and the establishment of the drug abuse program at Mendocino is a case study in the mobilization of an existing facility to provide a new type of community service. Mendocino is one of the fourteen mental hospitals in the California Department of Mental Hygiene. It serves thirteen northern California communities

from San Francisco to the Oregon border, so that rural, suburban and urban areas are represented. The hospital is located at Talmage, about 100 miles north of San Francisco, in a beautiful woodland setting.

Admission voluntary

The hospital has assigned two 38-bed units to the drug abuse program; these units together admit between forty and sixty patients a month. Admission is voluntary and based on community referral. The youngest patients are 16, but most are in the 18-to-25 range. Identifiable sub-culture groups include the Haight-Ashbury hippies, the "street hypes" of the urban areas, and college and high-school students. A prominent characteristic of the patient population is multiple drug use: most patients have used three or four psychoactive drugs, and some as many as a dozen.

The facility is run on an open-door basis, with minimal staffing and maximum patient participation. We have restructured this part of the hospital milieu totally, to provide a dynamic and flexible setting that can accommodate innovation. Many different kinds of therapy are used, to accomplish various ends: vigorous gut-level attacks on the drug user's way of life are balanced by humanistic supportive techniques. Attack therapy sessions generate honesty; encounter groups facilitate non-verbal communication; daily meditation aims at self-knowledge and the mastering of impulses; "slip games" are a type of psycho-charade designed to promote positive social action and combat shyness; concept groups provoke meaningful discussion and help overcome bias; other therapies arise in response to the needs of patients or to exploit the special abilities and interests of staff members.

The fundamental concept of the program is revealed by the fact that the patients have called themselves "The Family;" this indicates the strength of their relationships and the intensity of their 24-hour-a-day living experience.

We believe that we have tapped the creative potential of the drug-dependent person as we had previously done in our alcoholism program, about which a survey team reported: "The patients are almost made to feel that they run the program, a state of mind that the survey team found highly desirable."* We consider this involvement the vital ingredient of our program and probably the only way in which the inevitable in-group pressures can be mobilized to maintain a drug-free environment. In over two years we have had no major incidents of drug trafficking. Assuming responsibility for helping newcomers, or becoming a leader in program activities, leads the patient from the fantasy life of the drug user to what would be described in street parlance as "making it on the natch."

Follow-up essential

We believe we have shown that a drug-free environment can be achieved within a voluntary, open hospital setting; but follow-up in the even more open setting of the community is essential. A patient leaving the hospital on his own and re-entering the community in which he acquired the habit of drug abuse in the first place has minimal defences against a return to the practice. With this in mind, the Family have set up their own halfway houses or "Family Homes," in cooperation with community personnel. The first was established in San Francisco, the second in a coastal community. In this way, the hospital group extended some of its strength into the community.

To finance the Family Homes, the members embarked on a number of money-making activities: they got a contract with an airline to classify parts on a piece-work basis,

[Continued on p. 14]

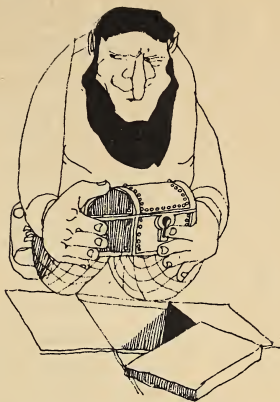
**The Treatment of Alcoholism—A Study of Programs and Problems*, a monograph published by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Washington, D.C., 1967.

The Great Am



By John Wilcock and Howard Shoemaker

Tea Ceremony



"I don't really enjoy smoking pot, man—I just dig the ritual."

d by permission from **The Realist** (No. 66, April, 1966). Copyright, 1966, by **The Realist**.

[Continued from p. 11]

they have a large garden in which they grow vegetables for market, and they also have a candle and leather-craft factory. In effect, the members of the Family were paying for their homes before they moved into them.

During the last fifteen months, the Mendocino drug program has reached even further into the community—in the area of preventive education. Once the patients have become responsibly active in their own program, they constitute the essential element in these activities: they can establish the relationship of trust with the teen-agers that must precede any successful educational effort.

Start a dialogue

There are several steps in our basic strategy for community education. In a typical situation, the first thing that happens is that key hospital staff and Family members meet with the people concerned in the community and explore the nature and extent of the problem and what constructive action can be taken. Then panels composed of staff and senior patients make presentations to health and welfare councils, agency personnel, school boards and administrators, law-enforcement departments and civic organizations. The presentations prepare these community groups for direct contact with teachers, parents and the young people themselves. Later on, similar panels are presented in the schools. After the panel presentation, the audience divides into small groups in which selected patients meet the students on a personal basis while staff consult with the school faculty. These are followed, on the same day, by similar evening presentations to parents and other interested members of the community; the aim is to precipitate a dialogue that will overcome the suspicion, mistrust and lack of communication that is generally evident. To date, we have worked with some thirty school systems.

A specific application, differing in some details, was in

one of our small coastal towns which recently experienced an influx of people who had been living in the drug-oriented areas of several metropolitan cities. Their arrival seemed to coincide with an explosion of drug use in the local high school. School authorities became aware of marijuana use and, very shortly thereafter, of amphetamine use—both oral and injective.

Ex-users as counsellors

Our response, at the invitation of the school, was swift and intensive. Selected senior Family members spent a day in the school, meeting with small groups of students while staff met with faculty. An evening presentation several days later was attended by well over 1,000 people—one-third of the population of the town. Student leaders, including drug experimenters, visited the hospital for further group sessions. Finally, several senior patient leaders were appointed as salaried drug abuse counsellors to students, teachers and agency personnel. A dozen others have been hired by hospitals and clinics in other communities.

We have made similar frontal attacks in more than a dozen other communities—serving as a resource for parents who discover that their children are using drugs, and providing formal seminars for professionals; we have been consulting with the faculty of a state college after they discovered a high correlation between drug experimentation and suicide attempts among their students; and some of our senior patients have functioned as group leaders in a probation officer's delinquency prevention group. In all cases, senior Family members have been involved.

A working model

What I have described above is a pilot effort aimed at preventing drug abuse through community education. The knowledge we have gained in developing and operating a relatively effective drug abuse program in the hospital, we

have applied in preventive work with school-age children, parents, teachers, and other community groups. The involvement of patients in this program constitutes a working model that other mental-health centres might well consider.

[Le directeur d'un programme de prévention de l'abus des drogues organisé dans un hôpital pour malades mentaux de l'Etat de Californie, décrit en quoi consiste ce programme. Les patients envoyés par des agences locales sont hospitalisés dans cet établissement, qui est situé à la campagne, loin du milieu des narcomanes. Le programme pour les patients hospitalisés comporte un fort degré de participation des patients à la thérapie en groupe, et à d'autres activités. Des établissements intermédiaires financés par les patients eux-mêmes facilitent leur retour à la vie ordinaire. Enfin, d'anciens patients jouent un rôle important dans l'oeuvre d'éducation visant à prévenir l'abus des drogues chez d'autres jeunes gens.]

Opposé:

Le doyen des étudiants du California State College, à Long Beach—région où l'abus des drogues parmi les étudiants sévit plus que partout ailleurs—offre quelques suggestions aux enseignants. En voici quelques-unes: Sachez en quoi consiste le problème; donnez aux usagers des drogues la possibilité de vous dire la vérité, sans risquer de punition; évitez une ligne de conduite trop stricte concernant l'usage des drogues; efforcez-vous de toujours donner le bon exemple; préparez des moyens constructifs qui permettront aux jeunes de dépenser leur trop-plein d'énergie; donnez des renseignements exacts; enfin, "écoutez, écoutez, écoutez" ce que les jeunes, perplexes et angoissés, ont à vous dire.

Drug Abuse and the New Generation

By George D. Demos, M.S., Ph.D.

A young man riding his motorcycle on a college campus road crashed into a wall without attempting to stop. It looked like a suicide attempt. Later this student admitted he had been experimenting with LSD. The line between the real world and fantasy was blurred; somehow he assumed that he would not be hurt.

Another student, a young girl brought up in a stern fundamentalist church, tried LSD only once while visiting San Francisco's Haight-Ashbury district with a friend. Despite the fact that she ingested no more hallucinogenic drugs, she was still experiencing hallucinations two months later.

Another student, a bright, articulate philosophy major, felt that through taking drugs he was able to understand himself and his discipline "at a very deep level." He was brought to the college counseling center hallucinating and completely out of touch with reality. He had to be taken to the local state hospital.

A high school sophomore who had been riding with a group of youngsters in an automobile at excessive speeds did not negotiate a turn, and one of the teen-age occupants was killed. The driver was asked how and why. She said, "All the kids were popping pills and smoking pot. I get my highs through 'Mary Jane'—you get yours through alcohol. What's the difference?"

There was yet another young man—and I continue to recall his vitriolic words: "You hypocrites! How can you tell

Mr. Demos is Dean of Students at California State College at Long Beach. This article is reprinted, slightly abridged, from *Phi Delta Kappan*, Vol. L, No. 4, December, 1968.

me not to try marijuana when you know damn well alcohol and nicotine are more dangerous?"

A hippie says, "Love—maybe we can build a society based on love and peace. We're doves, you know. What good has force really done? What has it really accomplished? Maybe we can at least point out the hypocrisy of the establishment. Maybe this movement will rock them enough to at least question some of their attitudes, values, beliefs, and behaviors, and maybe you'll realize you've got hangups, too."

Drug abuse only a symptom

These are actual statements made to me recently by young people. They were made in Long Beach, San Francisco, London, and Paris. Who are these gadflies—these non-conformists? Are they hippies, beatniks, spoiled brats, poor students, rationalizing failures, confused young adults, future leaders, addicts, dropouts, Communists, anarchists? I see them, in the main, as bright, middle-class, intelligent, thinking, caring, anti-materialistic, valuing, potential future leaders of this nation. I find that they firmly believe they have better answers to their problems than we have. It is an oversimplification to conclude that drugs are *causing* the problems of youth. *Drug abuse is a symptom of more basic underlying problems facing our society.* To aim simply at "eradicating" drug abuse is not the answer. We must look for solutions on a much broader and deeper scale.

Interestingly, researchers who are exploring the drug problem in Europe find that it has not reached the proportions there that it has in the United States. London may be an exception, but LSD is not the problem there. London youths use marijuana primarily. The fad has been heavily influenced by young musical leaders in England. In discussing the problem of drug use with several Europeans, I found some concern that as the European standard of living improves, a larger middle class emerges, communication

through mass media widens, and a period of drug abuse follows. There is a striking similarity between changes occurring in some of the major European cities and our own major cities, not all of them superficial. Basic attitudes and values are similar; for example, the emphasis on materialism, the educational pressures, the success ethic.

We may eventually conclude that the reactions of this generation of young people to the problems they face are in many respects healthy, certainly preferable to the apathy of an earlier generation. Young people are striving for answers—sometimes in a misguided way, to be sure—but the struggle must be applauded. An analogy can be drawn with the Negro “revolution.” As tragic as some of its concomitant effects may be, visible changes are coming about as a result of the Negro revolt.

Prevent as well as cure

What are appropriate courses of action for educators charged with influencing conduct of the young? Obviously, we must deal not merely with individuals who are presently using and abusing drugs but also with potential users, persons who may have a propensity for such experiences. Our concern should be with prevention as well as cure.

First of all, I would suggest that *educators become more familiar with the subject matter*. Much of the drug literature is replete with myths, half-truths, old wives’ tales, and gross misinformation regarding the effects of various kinds of drugs. This is particularly true for marijuana. Much misinformation has been purveyed by law enforcers about the effects of marijuana. Their point of view usually reflects dealings with offenders rather than contacts with the large numbers of people who have not been involved with the law. Their conclusions are likely to be based upon an inadequate sample.

Be aware of the differences between *narcotics* and *other drugs*. Too frequently the terms are used interchangeably.

There is no quicker way to lose a knowledgeable audience than to refer to LSD or marijuana as a narcotic.

Provide avenues for drug users and potential users to level with you with impunity. Is there a place well-known to young people in your school and community where talk about drugs and drug usage is "privileged communication"? It is a common misapprehension that if a student reveals use of a drug or plans to do so, it is incumbent upon one to report him to the police; otherwise, it is assumed, one may become accessory to a felony. This is false.

Rigid policies shortsighted

Moreover, for educational institutions to have *rigid* policies or regulations regarding drug use appears shortsighted. It fails to take into account the fact that we cannot dispose of the problem by making rules. Too often, in adhering to rigid policy, we suspend drug users or expel them from the institution; or we refer them immediately to the local police, who may impose severe sanctions for possession or use of specific drugs. Isn't this sometimes done only because it is the easy way out or, worse, to satisfy the board of trustees or PTA? Is it any wonder that we are called the "expedient generation" or the "sold-out society"?

Strive to be a better model. Young people are searching for authentic models. "What should I be like?" is the question most frequently heard as one "listens with a third ear." But they reject the so-called establishment, and I contend that the reason young people do not emulate us is simply that we are generally poor models. This theme hardly needs elaboration, although it needs analysis. Have we muffed our opportunities any more disastrously than earlier generations? Perhaps our failings are only more obvious to a generation brought up on "instant communication." There are formidable barriers of tradition and image for teachers who would serve as models, but these barriers are not insuperable.

Let us influence the young by being authentic, open, trusting, and honest. Let us stand up, speak out, be ourselves, and listen. Let us strive for understanding but also work toward bringing about wholesome changes. Just working at it helps, as in therapy we have evidence that it isn't necessary to have the solutions to problems in clear-cut fashion. Simply confronting the problem and genuinely working at it can be therapeutic.

Listen to the young. What are they saying? Is there any validity to their charges? How viable are their dreams and aspirations? You may sometimes find their viewpoints refreshing and creative if you will but listen. I do not believe young people will *solve* most of our problems; but I am frequently amazed at their creativity and their sense of justice, equality, and fair play.

Constructive outlets are needed. It is a cliché that college boys who used to chase college girls now seem more interested in chasing college administrators. Who can say which is a more worthwhile expenditure of youthful energy?

Use encounter groups

It is a wise person who can divert potentially destructive energies into constructive channels. Administrators are facing the problem not only at the college level but increasingly in high schools and junior highs. We must seek and provide many creative outlets. One concrete suggestion I would make is acceptance of basic encounter groups. Basic encounter in the "vertical marathon," for example, can help considerably.* Let the hippies, the drug users, the militants, and the activists have their say. Let us accept confrontation

*A "vertical marathon" is an intensive group experience of from twelve to forty-eight hours' duration involving individuals from various segments of society, e.g., students, teachers, administrators, community leaders, etc. See George D. Demos, "Marathon Psychotherapy: A New Therapeutic Modality," *Marriage Counselling Quarterly*, November, 1967.—G. D. D.

by them. I would even provide vehicles of communication and sounding boards for their ideas.

The "experimental college" or "free university" has created much interest on East and West Coast campuses. At California State College at Long Beach, for example, students themselves create the courses, select the reading materials, and approve the speakers. They are virtually free to do whatever they like in class. The college provides space and personnel services as requested by the students.

Let them blow off steam

In the past we have felt comfortable in dealing with the clean-shaven, crew-cut student government leader. Consciously or unconsciously, many adults fail to develop adequate communication with those who do not fit this stereotype. It is equally true, of course, that many of the *avant-garde* are suspicious of adults. Thus it behooves us to put forth considerable effort to talk with and understand them. Let them challenge our facades, rationalizations, and logic-tight mental compartments. Let them express hostility to us. It is ironic but true that when we can express emotion directly, even "negative feelings," we develop more positive attitudes toward a person. I believe that if students let off steam in our presence we will discover the generation gap narrowing.

Offer youth accurate information. Educators can ask behavioral scientists to deal with data regarding drugs. We should not leave it solely in the hands of law enforcement personnel. Police cannot be expected to be knowledgeable about causal relationships, experimental design, levels of confidence, and statistical inference. Inaccurate information widens the credibility gap between youth and the adult society.

We need expanded counseling for young people regarding the turmoil in which they are caught up. Group experiences of all kinds need to be provided, programs geared to util-

izing youthful talent in coping with societal problems. We need to become more involved with all kinds of students, but particularly those who have symptoms of drug usage. Not only should we work with the typical student, the clean-cut student leader or athlete, but with the atypical student—the hippie and the pseudohippie.

Bring together a variety of disciplines. Bring together law enforcement officials, psychologists, psychiatrists, members from the medical profession, the pharmaceutical companies, and other agencies of society concerned with the drug problem. Listen and learn from each other, and then proceed to help bring about necessary changes.

Finally, remember that there are no simple answers to the perplexing problems facing man. Perhaps this is the lesson that young people must eventually learn for themselves. It is desirable to search for the truth, and there is no better way than reality confrontation and hard work. The key words of the psychedelic cult, “turn on, tune in, and drop out,” represent irresponsible and defeatist attitudes. A more vigorous and viable approach would be to *turn on* one’s potential to cope with the problems facing us in a dynamic society; *tune in* to what others are saying, becoming more sensitive to the world around us; and *drop in* to the real world, taking a more active role in ameliorating its shortcomings.

Suggested Readings

- Barbiturates as Addicting Drugs.* U.S. Public Health Service Publication No. 545 (revised June, 1964).
- BARRON, F., *et al.* “The Hallucinogenic Drugs,” *Scientific American*, April, 1964, pp. 29-37.
- BLUM, RICHARD H., *et al.* *Utopiates: The Use and Users of LSD-25.* New York: Atherton Press, 1964.
- COHEN, S. “A Classification of LSD Complications,” *Psychosomatics*, May-June, 1966, p. 182.
- COHEN, SIDNEY. *The Beyond Within: The LSD Story.* New York: Atheneum, 1964.

- DALRYMPLE, W. "A Doctor Speaks of Marijuana and Other 'Drugs,'" *Journal of American Colleges Health Association*, February, 1966, p. 218.
- DEMOS, GEORGE; SHAINLINE, JOHN; and THOMAS, WAYNE. *Drug Abuse and You*. New York: Chronicle Guidance Publications, 1968.
- EVIN, D. (ed.). *The Drug Experience*. New York: Arion Press, Evergreen Black Cat Edition, 1961.
- EDDY, N. B., et al. "Drug Dependence: Its Significance and Characteristics," *Bulletin, World Health Organization*, Vol. 32, 1965, p. 721.
- FORT, J. "The Problem of Barbiturates in the USA," *Narcotics*, January-March, 1964, pp. 17-35.
- GOLDSTEIN, RICHARD. *1 in 7*. New York: Walker, 1966.
- HOFFER, A. "D-lysergic Acid Diethylamide (LSD), A Review of Its Present Status," *Clinical Pharmacology Therapy*, March-April, 1965, p. 183.
- LOURIA, DONALD. *Nightmare Drugs*. New York: Pocket Books, 1966.
- LOWEN, ALEXANDER. *The Betrayal of the Body*. New York: Macmillan, 1966.
- MAYOR'S COMMITTEE ON MARIJUANA. *The Marijuana Problem in the City of New York; Sociological, Medical, Psychological and Pharmacological Studies*. Lancaster, Pa.: Jacques Cattell Press, 1944.
- MCGLOTHLIN, W. H. "Hallucinogenic Drugs: A Perspective," *Psychodelic Review*, No. 6, 1965.
- MCGLOTHLIN, W. H., and COHEN, S. "The Use of Hallucinogenic Drugs Among College Students." *American Journal of Psychiatry*, November, 1965, pp. 572-74.
- SEEVERS, M. H. "Abuse of Barbiturates and Amphetamines," *Post-graduate Medical Journal*, January, 1965, pp. 45-51.
- SHEPARD, JACK. "I Popped in the Pill. I'm Off," *Look Magazine*. August 23, 1967.
- SMITH, D. R. "Drug Intoxication: Barbiturates and Tranquilizers," *Applied Therapy*, March, 1964, pp. 219-22.
- SOLOMON, DAVID (ed.). *LSD: The Consciousness Expanding Drug*. New York: G. P. Putnam's Berkeley Medallion Books, 1964.
- SOLOMON, DAVID (ed.). *The Marijuana Papers*. Indianapolis: Bobbs-Merrill, 1966.
- Student Reference Sheet: Hallucinogenic Drugs*. U.S. Department of Health, Education, and Welfare, FDA, 1965.
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Summer, 1969

The Role of Law in the Control Of Alcohol and Drug Use

By Margaret E. Hughes, M.S.W., LL.M.

Law is the instrument that our society uses to create, maintain and enforce desired relationships between individuals and the state, and between individuals within the state. For our purposes in this discussion, we may divide the law into two categories: criminal and civil. In the former, the state initiates the action and is responsible for carrying it through prosecution to conviction or acquittal. In the latter, the state merely provides the courts and officers that an aggrieved citizen may use to obtain relief. At the moment, it is the criminal law that is the primary means of controlling the use of alcohol and drugs.

In our society, laws are based on the principle that the personal freedom of the individual members of society must be protected. This is particularly true of our criminal law, which is based on the belief that the state should penalize or

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confine a subject only if he is found guilty of conduct that has interfered with some right deemed important to society as a whole. In other words, society does not interfere with the personal freedom of its individual members unless it is absolutely necessary; and the determination of the situations in which interference is deemed absolutely necessary depends on one's view of the purpose of the criminal law.

Two schools of thought

At the present time there are two main schools of thought on the purpose of the criminal law, and this difference of opinion has important implications for us. Perhaps the best known proponent of the first school is Lord Devlin, a highly respected English criminal judge. According to Lord Devlin,¹ a society must possess a common morality; and because society has the right to preserve itself, it has an unconditional right to enforce this common morality. He says that the chief method of enforcing this morality is the enactment and enforcement of criminal law. For example, in terms of this discussion, if addiction to alcohol is sinful conduct, society has the right to interfere with the alcoholic's personal freedom and in effect "save the alcoholic from himself."

The second view of the purpose of the criminal law is exemplified in the report to the Parliament of the United Kingdom, in 1957, of a special committee on homosexual offences and prostitution headed by Sir John Wolfenden. The committee took the view that the function of the criminal law is "to preserve public order and decency, to protect the citizen from what is offensive or injurious, and to provide sufficient safeguards against exploitation and corruption of others, particularly those who are specially vulnerable because they are young, weak in body or mind, inexperienced, or in a state of special physical, official or economic dependence."²

The committee went on to say: "It is not, in our view, the function of the law to intervene in the private lives of citizens, or to seek to enforce any particular pattern of behaviour,

further than is necessary to carry out the purposes we have outlined.”³

The committee stressed that it was not condoning or encouraging private immorality, but that “there must remain a realm of private morality and immorality which is, in brief and crude terms, not the law’s business.”⁴ In other words, in terms of this discussion, the mere fact that a person is an alcoholic would be insufficient to justify society’s interference with his liberty. Before interference would be justified, the person, as a result of using alcohol, would have had to commit some act that had in some way endangered the well-being of others.

The Wolfenden Committee’s view of the distinction between law and morality is not new. According to John M. Murtagh, Chief Justice of the Court of Special Sessions in New York City, St. Thomas Aquinas was saying very much the same thing in the thirteenth century. Judge Murtagh says that his own philosophy of the criminal law is based in large measure on the teachings of St. Thomas, which he describes as follows:

Basically he [Aquinas] taught that human law, or in this connection, criminal law, must be based on the moral law, that in effect we must start with the violations of the moral law or, if you prefer, of accepted standards of social behavior. But he went on, and this is what I want to emphasize: it is not the function of human law or criminal law to take over the entire moral law; rather human law should limit itself to implementing the moral law in that narrow sphere of activities where violations thereof have a substantial impact on others. In plain English he taught that criminal law should be dealing with acts of violence against the person and property; that it was not the function of human law to make men saints—that was largely a matter for the individual himself, and for society through the home, the church, and the school, by teaching and encouraging morality. But the law should not avail itself of the organized authority of the state to force a person to become saintly whether he wills it or not. He taught that indeed we, as individuals and as an organized community, have a right and a responsibility to persuade and to educate, but not to coerce.⁵

Now I am not saying that either of these philosophies of

the purpose of the criminal law is the one in which you must believe; what I am saying is that you must choose a philosophy, and the choice you make will undoubtedly affect your opinion of the role the criminal law should play in the control of alcohol and drug use. I believe that although morality and the criminal law will overlap at times, crime cannot be equated with sin. As the Wolfenden Committee suggested, the state must not interfere with the freedom of an individual unless interference is necessary to preserve public order and decency or to protect other individuals from injury, exploitation or corruption. I want to make this clear because my philosophy will be reflected in any evaluation that I make of existing or proposed laws that are intended to control the use of alcohol and drugs.

Criminal law is intended to control conduct, whether we wish to control it because it is immoral or because it threatens public order and decency. Leaving aside for a moment the philosophical purpose, let us consider two essential ingredients of any successful criminal law. In our society, to be successful, a law must be supported by the majority of the population, and those who transgress it must be punished. Except in a police state, the laws must reflect the customs and attitudes of the majority of the people who are subject to them. Those who propose or enact laws often seem to assume that all the lawmaker has to do is declare "Be it enacted that . . ." and in some miraculous way the prescribed standard of conduct will effectuate itself. This is simply not the case.

Why Prohibition failed

The Ontario Temperance Act of 1916 illustrates this point. This Act forbade the possession, transportation and sale of intoxicating liquor except in very limited circumstances. As soon as it was enacted it was violated, in many cases quite openly, by a great number of people. Why? Because the legislators had not given adequate consideration to the attitudes of the population and to the available means of enforce-

ment. The law was in opposition to the customs and desires of too many people. The existing law-enforcement machinery was unable to eradicate the drinking habits of such a large proportion of the population. Evidently, the legislators had declared a prohibitive standard and assumed that it would somehow effectuate itself.⁶

True, no one is seriously proposing that we attempt total prohibition today; but prohibition taught us a lesson that we must bear in mind as we examine and propose revisions to our existing legislation.

When penalties are effective

The support of the majority of the population is not, in itself, sufficient to ensure that a criminal law will in fact regulate conduct. There will always be persons who will consider violating a law, whether or not they support it in theory. As a result, penalties for violations of the law are provided in the hope that the threat of punishment will supply a motive for a potential violator to refrain from doing what the law forbids. The effectiveness of a threat of punishment in controlling behavior depends upon four factors:

- the severity of the punishment;
- the speed with which it will be exacted;
- the degree of certainty that it will be exacted;⁷ and
- the ability of the actor to control his behavior.

This last factor is most significant. Without this ability, the deterrent effect of the threatened penalties will be negligible. For this reason, I will distinguish later on between the role of the law in controlling the social or non-addictive use of alcohol and other drugs and its role in controlling the use of these substances by addicts. The apparent inability of the addict to refrain from using alcohol or narcotics, regardless of the laws and the penalties threatened, makes this distinction essential.

Now that we have considered the function and the essential elements of a successful criminal law, let us examine our present laws. Do they reflect the attitude of the majority of the

population? Are they enforceable? Do they control the use of alcohol and drugs?

Today, mixed attitudes still exist towards the use of alcohol. To some, its use is sinful and should be condemned by the law; but I think it is fair to say that to the majority it is a source of pleasure and relaxation. Its use at home and at social gatherings is acceptable, provided that some degree of moderation is observed—at least in public. However, great reproach and disdain are directed towards those who show the effects of continual, excessive use of alcohol. The opposite attitude seems to exist towards the use of drugs. To a minority, drugs are a source of pleasure and relaxation; but to the majority, drugs are extremely dangerous and should only be used for medicinal purposes and under a doctor's supervision.

Present legal controls

What, then, are the applicable laws? Alcohol is available over the counter, without a prescription, to anyone over 21 years of age. The Criminal Code of Canada makes it an offence to create a disturbance in a public place by being drunk, and in Ontario, the Liquor Control Act makes it an offence to be drunk in a public place. The Ontario Liquor Control Act also provides for the issuing of an interdiction order, which is a judicial order prohibiting a named person from purchasing, possessing or consuming any liquor within the Province. There are drinking-driving offences, such as careless, impaired or intoxicated driving. However, as long as the individual drinks at home and does not reach the point where his use of liquor renders him incapable of managing his affairs, dangerous to himself or others, or mentally incompetent, the law leaves him alone.

Similarly, the drug addict is not fined or imprisoned merely because he is a drug addict. There is a strong tradition in English law that a person cannot be punished simply for being a certain sort of person; he can only be punished for committing an act that is proscribed or for failing to perform

an act that is required by law. Thus the drug addict is punished, not for being a drug addict, but for having been found in illegal possession of a narcotic, or trafficking in or importing a narcotic, at a specified time and in a specified place.

The drug addict can run afoul of the law in other ways: a narcotics user is generally unable to obtain enough drugs to support his habit legally, and must resort to illegal purchases. The expense of illegal purchases generally requires him to engage in other criminal activity for financial support, and thus he is likely to come into contact with other criminal laws such as the laws against theft.

The question now is, do these laws really control the use of alcohol and drugs in our society? Let us begin with the use of alcohol. The deterrent function of the criminal law is most effective with people who are not alcoholics—who have not lost control of their drinking. If moderate drinkers wish to avoid a prescribed penalty, they will not engage in the prohibited act—whether that act be public drunkenness, impaired driving or any other offence. It is with non-addicted drinkers as well that social control in the form of interdiction has the greatest chance of being effective.

Reasonable interference

Although technically the present laws, such as the prohibition against impaired driving, do constitute an interference with the freedom of those people who are able and prepared to use alcohol moderately, the interference is reasonable and, I think, is accepted by the majority of the population on the basis of the need to preserve public order and to protect others from injury. In fact, our present laws do not interfere to any greater extent with the freedom of those who are *not* willing or able to use alcohol moderately. Society will not interfere with the freedom of these people unless they violate a criminal law.

How effective are the laws in controlling the actions of those

who wish to use narcotics socially? Indeed, can there be such a person as a "social narcotics user"? The difference between the use of alcohol and the use of narcotics is not merely that alcohol is legally available and that no prescription is required to obtain it, but that only a relatively small proportion of those who drink become alcoholics. In contrast, the continual use of narcotics almost inevitably results in addiction.

Are the drug laws succeeding?

For our purposes let us define a social drug user as a user who is not addicted. The law is attempting to control his use of narcotics and certain other drugs by making it virtually impossible for him to obtain them legally and by providing very severe penalties if they are found in his possession, even in the privacy of his own home. However, the frequent reports about the widespread use of drugs—generally non-narcotic and apparently non-addictive—by hippies and other young people make one question the degree to which the law is succeeding in its attempts at control, even with people who are apparently not addicts.

Finally, let us consider the extent to which the law controls the use of alcohol or narcotics by addicts. I think we can sum it up by saying that the deterrent function of criminal law is relatively ineffective with this group of people; the same can be said for interdiction orders. Our laws were originally based on the belief that addiction, especially to alcohol, was the result of the addict's moral weakness and that the deterrent effect of a jail sentence would induce him to "stiffen his spine" and control his behavior. If he did not so regulate himself, his moral lapse warranted punishment.

Today, many authorities believe that an addict is incapable of refraining from consuming alcohol or narcotics. He cannot control his need for these substances and therefore he is not deterred by the prospect of penalties—regardless of their severity or the certainty of their exaction. Addiction, in this view, is a disease; and punishing an addict without providing

treatment for his disease does not deter him from repeating his offence, nor does it deter other addicts from committing the same offence.

On the other hand, there is growing medical and legal support for the view that an addict *is* capable of some degree of control over his behavior and that in fact he often uses his addiction as a blanket justification for behavior that is irresponsible. On this view, the deterrent function of criminal law may well be effective with many addicts—depending upon the degree of control possessed by the particular addict involved.

The relative ineffectiveness of the criminal law as a deterrent in the case of people who have lost control of their behavior has been recognized, and our laws are in a state of transition. Our laws do not require that medical treatment be given to imprisoned alcoholics, whether they are convicted of alcohol-related or other crimes.

A questionable distinction

On the other hand, the federal Narcotic Control Act of 1961 contains a provision for the treatment of imprisoned drug addicts in special centres. This provision is now being implemented. However, the Act's treatment provisions apply only to those convicted of narcotic offences: possession of, or trafficking in, narcotics. In other words, if a drug addict traffics in narcotics to support his habit he may receive treatment; but another addict, caught stealing to support his habit, will not—he is merely imprisoned. The wisdom of this distinction is questionable.

We are moving towards a general acceptance of the view that addiction, to alcohol or narcotics, is not a moral lapse but rather a disease over which the addict may or may not have some degree of control. As acceptance of this concept increases, we will reach the stage where treatment will be available for all addicts who have been convicted of criminal offences and sentenced to jail or prison. This raises several

interesting problems. Can we force an addict to accept treatment aimed at curing him? Assuming that we can, should we?

If an addict is convicted of an offence, should he be allowed to choose between jail or treatment, or should society make the decision for him? If the choice is up to him, and the conditions of treatment are less congenial than jail, few addicts are likely to opt for treatment. Should we be required to keep the length of mandatory treatment sentences proportionate to the sentence that the addict would have received if he had been jailed for the offence? Taking the Narcotic Control Act as an example: if the maximum sentence for possession of narcotics is seven years, should we be able to sentence the addict to ten years' compulsory treatment—or even worse, to treatment for an indeterminate sentence, perhaps until he is completely cured? This might mean a lifetime of confinement.

The demand for compulsory treatment

This is not merely an academic discussion. The reluctance of addicts to admit that they have a problem and to enter into and sustain a treatment program voluntarily has led members of the helping professions to demand that the addict, for his own good, be forcibly brought into contact with treatment. Some have suggested that this should be accomplished by seizing upon an addict's infraction of some law, even if it is a minor infraction that might otherwise be overlooked, to convict him and give a lengthy sentence so that ample time for treatment would be available. In fact, it has even been suggested that we develop a civil commitment procedure whereby we could compel an addict to undergo compulsory treatment even though he has not been detected in the commission of any offence.

One's evaluation of the pros and cons of these various solutions will depend upon one's basic philosophy of the purpose of the criminal law. The ambition to help our suffering fellow man is a laudable one, and from the limited field experience

have had as a social worker I know the frustration that one can feel in trying to help people. However, I do not believe that the purpose of the law is to make men saints—to help them in spite of themselves—but rather that society must interfere with the liberty of a subject only when he has committed some act that endangers public order and decency.

Will compulsory treatment work?

However, if one believes that society should interfere with an individual's liberty to help him in spite of himself, the gain to be realized from such a sacrifice of civil liberties must be evaluated. Can we successfully impose treatment upon an addict against his will? Is not personal motivation essential? I do not believe that it makes much difference to an addict who is deprived of his liberty that this deprivation is to help him and not to punish him. Compulsion generates anger, resentment, and resistance—none of which are conducive to rehabilitation. As a result, if it cannot be demonstrated that in at least the majority of cases we can in fact successfully impose treatment and cure the addict despite himself, the sacrifice of civil liberties is too great. The end will not justify the means.

Prospects for the future

Today the proposition is firmly held that a man may be taken out of society only on the basis of what he has done and not on the basis of the sort of person he is; and I think it is fair to say that it will be difficult to reshape our legal process to allow the compulsory confinement of a sane person for treatment of a non-contagious disease when he has not been convicted of a criminal offence. This does not mean, however, that such legislation is impossible to obtain in the future. It is possible; but its passage and its acceptance by the majority of the population will require that the helping professions advocating such a fundamental change undertake an extensive public-relations program. Part of this program will un-

doubtedly need to be a demonstration that a much higher rate of cures is achievable with present treatment techniques than the public currently believes is possible.

References

- ¹ The Hon. Sir Patrick Devlin, *The Enforcement of Morals* (Macabean Lecture in Jurisprudence of the British Academy, 1959). London: Oxford University Press.
- ² *Report of the Committee on Homosexual Offences and Prostitution* (London: H.M. Stationery Office, 1957), para. 13.
- ³ *Ibid.*, para. 14.
- ⁴ *Ibid.*, para. 62.
- ⁵ John M. Murtagh, "Alcohol and the Law," in S. P. Lucia (ed.), *Alcohol and Civilization* (New York: McGraw-Hill, 1963), pp. 234-5.
- ⁶ B. Shartel and B. J. George, Jr., *Readings in Legal Methods* (Ann Arbor: The Overbeck Co., 1962), p. 50.
- ⁷ *Ibid.*, p. 60.

[L'auteur fait observer qu'il existe deux opinions sur le rapport entre le droit pénal et les principes moraux privés. Certains philosophes du droit croient que la société ne peut survivre si elle n'a pas un code moral commun et, par conséquent, qu'elle est en droit de faire observer un code moral commun par le truchement du droit pénal. D'autres croient que la société n'a pas le droit d'intervenir dans les actes de l'individu, sauf si cette intervention est nécessaire pour préserver les droits d'autrui. L'auteur indique son adhésion à cette dernière opinion et examine de ce point de vue les lois actuelles et les projets de loi sur l'usage de l'alcool et des drogues.]

The Role of the Union In Industrial Alcoholism Programs

**By James A. Belasco, Ph.D., Harrison M. Trice, Ph.D.,
And George Ritzer, Ph.D.**

The current efforts to "do something" about alcoholism in industry have largely ignored the labor union. Company programs and policies that have blossomed forth in recent years have been established under the naive assumption that the union will "go along." Many of the difficulties encountered by company programs, and the gap between the well-stated policy and the actual conduct of the program at lower levels in the organization, may be attributable to this oversight.

Union support essential

It is axiomatic that the company that plans to install a new piece of equipment ignores the union at its peril. The same is true of the company-sponsored alcoholism program. Union support at both the policy-making level and the action level is an essential prerequisite of any successful attempt to treat the problem of alcoholism in industry. In the following pages we will outline the problems that alcoholism poses for the union, and discuss the ways in which unions can participate in various types of programs.

The costs that alcoholism extracts in terms of absenteeism and inefficiency pale before the personal problem that the alcoholic poses for the union steward in his area. "No single

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situation can lead to an ulcer faster than to have an alcoholic on your hands," one steward told us. Another said, "I would take five wildcat walkouts rather than one alcoholic."

The steward bears the brunt of the alcoholism problem on the job. He sees at first hand the damage the alcoholic is doing to his job and his family. Having often known the alcoholic for years, both in the plant and socially, the steward sees the troubles his wife and children contend with. In addition, the steward sees all the early signs of physical deterioration in the alcoholic himself, such as red or bleary eyes, hand tremors, and flushed face. All this close-up exposure is likely to instil in the steward a deep desire to help the alcoholic.

Covering-up no answer

However, the steward doesn't know how to help. Initially he excuses the behavior. He may say to himself, "After all, John may drink a little too much, but he's got so many problems that it's enough to drive anyone to drink. Besides, John and I have always drunk together in the past; he'll get over this and then he'll be himself again." These excuses lead to some early cover-up activity as the steward tries to help the alcoholic by relieving some of the pressures on him. The tragedy of the situation is that such "help" only harms the alcoholic.

Many companies have established policies and programs to deal with alcoholism among their employees. The policy-program approach involves five main components:

1. Management must understand and accept that alcoholism is an illness, not a moral defect.
2. Supervisors must be motivated to identify alcoholics and refer them to treatment.
3. The alcoholic employee must be motivated to accept treatment.
4. Treatment and rehabilitation facilities must be arranged for or established.

5. There must be follow-up, to ensure that the program is consistently applied.

Motivating the alcoholic to accept treatment is crucial to the success of the program. The alcoholic has spent many years constructing an elaborate set of defences; typically he will deny that he has a drinking problem, and assert that he can stop drinking any time he wants to. To break through these defences, it is necessary to precipitate a crisis that seriously threatens the alcoholic and makes him realize that life with alcohol is far more difficult and complicated for him than life without it.

An industrial alcoholism program seeks to create such a crisis for an alcoholic employee through the application of what has been called "constructive coercion". In this approach the alcoholic is offered a way back to normal life through treatment, but is made aware that his job is in jeopardy if he refuses treatment or fails to make progress. To make the program work, coercion must be applied consistently—right up to and including discharge, if discharge turns out to be necessary.

Options for the union

In this sort of situation, the union finds itself caught in the middle—obliged to defend its members in disciplinary cases, yet aware that only firm and consistent discipline can help the alcoholic. Our discussions with officials of more than forty companies and unions indicate that a union may adopt any one of three policies towards alcoholism among its members:

- it may adopt a purely defensive role in the company's alcoholism program, confining its actions to contesting disciplinary measures in cases of problem drinking;

- it may run an alcoholism program itself; or,

- it may cooperate with management in a joint program.

Sitting on the sidelines and allowing management to carry the full burden of treating alcoholics may seem to be the

easiest way out for the union, but this policy is not without its pitfalls: in this game, even spectators run the risk of injury. In the first place, the union business agent or international representative who adopts this hands-off policy is likely to come under attack both from within his union and from management.

Risk of internal conflict

Simply fighting the discharge or other disciplinary consequences of a member's drinking problem may seem the safest course of action for the international officer, but it commits the shop steward to the more-or-less permanently unhappy position of not being able to do anything about the problem. Furthermore, the rank-and-file members are not likely to be favorably disposed to a do-nothing international, particularly in a problem that is as mixed-up and confusing as alcoholism. In short, the union that retreats into a purely defensive position runs the risk of considerable internal conflict.

Management also is likely to be troubled by a union that is unwilling to take any positive action. An unwilling union puts the whole burden on management. Working through or with the union is usually one of the best ways of dealing with the problem of alcoholism. When a union refuses to cooperate, management's ability to handle the problem effectively is reduced. Thus, the union leader who ignores the problem is courting trouble both from other union members and from management.

Of utmost importance is the fact that the alcoholic is the biggest loser from this hands-off policy on the part of the union. The reliance on discipline by management, and the use of defensive grievance-and-arbitration tactics by the union, permit the alcoholic to play one side off against the other—which helps to poison the union-management relationship—and still keep drinking all the while. It is not unusual for problem-drinking cases to drag on for eight or ten years while

union and management slug it out over whether the disciplinary action was for "just cause"—and all the while, the alcoholic is drinking himself to death. Thus, the purely defensive policy may seem the safest for the union; but in the long run it is the most expensive in terms of wasted time and energy and the loss of the alcoholic's abilities.

In situations where the union takes on itself the burden of helping alcoholics, there are a good many problems. In the first place, the union generally does not have the time, money, or facilities to do an adequate job of helping alcoholics. Union officers in general do not have the training to handle the problems of alcoholics. They are frequently not trained in counseling, and are generally unaware of the facilities available in the community. If they are unpaid officers an added burden is placed on them, since they are generally doing their union work in their spare time.

Steward may become bitter

A unilateral union program also creates a number of internal problems for the union. Both the rank and file and the stewards tend to look to the union leadership for policy decisions, guidance, and assistance. We have said that, in general, the leadership have neither the training nor the time to do an adequate job in the alcoholism area. If a steward requests the union's help with a problem drinker and the response is either ineffective or detrimental, the steward is likely to become embittered against the union superiors who "sold him a bill of goods."

When the union runs the alcoholism program unilaterally, the rank-and-file members also have a tendency to be unhappy. When emphasis is placed on alcoholism, usually at the expense of other activities, the "normal" rank and file tend to feel that they are being ignored; and this can lead to anger and frustration.

Finally, unilateral action by the union tends to disrupt the union-management relationship. The normal relationship is

marked by management action and union reaction. In this case, the union is in the unfamiliar position of being the initiator. This is a new role for the union, and tends to complicate overall union-management relations. Thus a unilateral union program, while better than none at all, is still subject to considerable problems.

Where employment is casual

Despite these objections, there are many situations in which a union-operated program is the only kind of program that is possible. This is likely to be true in occupations such as the construction trades or the performing arts, in which employment is casual and each job is of short duration. In these situations it is not feasible for employers to set up alcoholism programs; the alternatives are a union-operated program or no program at all.

The third possible policy is to cooperate with management in a joint program. On the whole, we have the impression that union officers are both attracted and repelled by the idea of some measure of cooperation with management over the alcoholism problem. On the positive side of the picture, shop stewards see cooperation as a great potential benefit to themselves and to the alcoholic. Through cooperation, they can have a procedure for referring alcoholics—a procedure that holds out the promise of realistic help for the afflicted union member and at the same time relieves the steward of the burden of carrying him.

Secondly, cooperation provides a real status boost to the union official, since in such an effort he achieves recognition as a full equal and partner with management. In this way he gains stature in the eyes of fellow union officers, management officials, and rank-and-file members. Thirdly, cooperation on this problem may be infectious and may spread to other areas of the union-management relationship. Through such a joint program the union can demonstrate to management its responsibility and its maturity. This can lead to ar

improvement in overall union-management relationships, which may allow the union to make gains that it otherwise would not have been able to make.

On the other side of the coin, however, this increased cooperation may well result in a lessening of the union's militancy in pressing the demands of its members. Cooperation with management will undoubtedly make union leaders more aware of and more sympathetic to the company's problems. The more a union leader is sympathetic to the company's position, the less likely he is to be a militant defender of union rights and membership demands. Such a cooperative stance by the union leadership is likely to give rise to cries of "collusion" from the rank and file, and such an accusation can be a severe political blow to any union leader.

Schism in the union

This is especially true since cooperation usually involves higher-level union officers—the business agent or the international representative. As these officers become more sympathetic to the company's position, the gap between the stewards and rank-and-file members on the one hand and these "cooperative" senior officers on the other can become a dangerous schism that can lead to all kinds of internal union conflicts, with local officers charging that the international officers have "sold out" to the company.

As serious as this problem is for internal union harmony, it pales before a consideration of the second major problem that cooperation with management in an alcoholism program poses for the union: the position the union is placed in due to the use of the policy-program approach in general and constructive coercion in particular.

From the point of view of the steward seeking advice and help on what to do with his alcoholic fellow member, there are at least three major defects in the traditional policy-program approach. In the first place, it has been our experience that many employees are reluctant to become in-

volved in any company-operated program. Their reluctance probably stems from awareness of the contempt and distrust in which the alcoholic is widely held; this awareness creates a desire to keep the mention of a man's drinking problem out of the company's records. These employees probably recognize that the confidentiality of company medical and personnel files is often a fiction—they know that in matters involving promotion or transfer, "confidential" files can be and often are made available to line management.

Why the steward may vacillate

The second obstacle is a reluctance on the part of the steward to confront the alcoholic and get him into treatment. Even though the steward recognizes the signs of alcoholism and wants to help the alcoholic, he continues to vacillate about what to do. Our discussions with many stewards indicate that this vacillation often arises out of the steward's belief that it is his responsibility to help the employee overcome his problem. This "do it myself" attitude stems both from cultural norms and from many union publications that he has read. From the steward's point of view, seeking outside help—referring the employee to the medical department, for example—is an admission of his own failure.

Pressures on the steward

Strong feelings among fellow workers that drinking problems should be "kept among the boys" also put pressure on the steward not to report the alcoholic employee. His fear of a charge of collusion with management reinforces these pressures. Stewards must be careful to avoid "cooperating" so much that they neglect their members' interests. A steward who cooperates *too* much with management is likely not to be re-elected.

In addition to the lack of support from members, many stewards have considerable doubts about their support from upper levels of the union. There emerges from our research

a very clear rift between the shop steward and higher union officers. "They just don't understand our problems" is a frequent comment by shop stewards. As a result, the steward often hesitates until the situation is beyond repair.

The absence of support either from above or from below means that the steward must be very certain in his own mind before he takes any action about the problem. The very process of referral to the medical department or clinic involves a labelling that is apparent to all concerned: to the steward, to the employee involved, and to his fellow workers. Placing the steward in a referral role adds to his reluctance to identify and confront the alcoholic until he is absolutely certain, beyond any doubt, that the problem exists.

Why coercion is necessary

As serious as this obstacle may be, the constructive-coercion aspect of the policy poses even more severe questions for the union. As any steward who has ever had an alcoholic in his department can testify, alcoholism is an unusual illness in at least one important respect: the sick person will not willingly accept treatment. It is a frustrating, thankless and almost impossible job to convince the alcoholic that drinking is the cause of his troubles. No matter how unpleasant the prospect may be, it is a simple fact of alcoholism that the alcoholic must generally be coerced into accepting treatment—even though treatment is clearly in his own best interests.

To break through the alcoholic's line of excuses and rationalizations, it is necessary to precipitate a crisis; and one of the most effective ways to do this is to place his job in jeopardy. For the alcoholic, his job is central to his belief that he "isn't that bad." But levelling with him, with a threat to his job, breaks through this line of resistance and confronts him with reality; and this confrontation is the essential first step to recovery. This is the heart of the constructive-coercion policy: a job threat, coupled with the offer of a way back through treatment.

Most union leaders agree with this policy in theory. It is relatively easy to recognize the uniqueness of alcoholism and the absolute necessity of this constructive coercion. Nevertheless, most union leaders would stop here and say "Yeah, *but*: that's fine on paper; in practice we can't stand by and watch you fire Johnny Jones even though he *may* be a dropout from the alcoholic treatment center." The simple fact of the matter is that cooperation with management compromises the union's traditional protective function, a function that an elected union officer ignores at his peril.

The union in two roles

In essence, meaningful cooperation makes the near-impossible demand that the union sit on both sides of the table at the same time. The union official must sit with management in confronting the alcoholic and must clearly communicate to him that unless he makes meaningful progress through therapy he runs the risk of being discharged. At the same time, he must sit with the alcoholic and defend him against any disciplinary action that the employer may take. This task is very difficult, if not impossible, since performing one function partially takes away the ability to perform the other. For example, the mere fact that the alcoholic knows the union will defend him against discharge reduces the effectiveness of the constructive-coercion policy.

Legal obligations

In order to cooperate with management and make the constructive-coercion policy more effective, can the union agree not to defend a member if he doesn't accept the help that has been offered? There are probably two barriers that prevent the union from doing this. The first is a matter of internal union politics: a refusal to defend a fellow member lays the steward open to the charge of being "soft on management." Secondly, the union has a legal obligation to represent all of its members adequately. Recent NLRB and court cases

in the United States have made it more difficult for a union to refuse the grievances of its members.*

Thus the union officer is locked in by the policy of constructive coercion. If in cooperating with management he agrees to the discharge of a union member, he may run into serious political problems and, in the United States, legal problems as well. If he continues to defend his fellow member he weakens the motivational power of the constructive-coercion policy.

Many union officers have told us, in great detail, how frustrated they feel about this policy. Most of them try to resolve the dilemma by playing a dual role: they cooperate with management in confronting the alcoholic and pressuring him to accept treatment; but, at the same time, they represent him if he requests it. There is no doubt that this ambiguous policy is the major obstacle to effective union cooperation on the alcoholism problem.

Suggestions for the future

In what we have written so far, we have pointed up the problems that confront the union in industrial alcoholism programs. We may have seemed pessimistic, but enthusiasm alone will not solve these problems; realism is necessary as well. In the following pages, we would like to make some suggestions for dealing with these problems.

*In Canadian federal law and in Ontario law, unions are obliged to take up the legitimate grievances of all members of the bargaining unit for which they are certified, whether the grievors are union members or not. On the other hand, unions are not obliged to take up weak grievances, and the policy of most Canadian unions is against proceeding with a grievance if the union grievance committee judges that the grievor's case is weak. The thinking behind this policy is that if a union were to take up all grievances, weak or not, then—apart from the waste of time that would be involved—the union would lose its credit with management and, ultimately, with its own members.—*Ed.*

Even if there is no formal alcoholism program in the company, it is a good idea for union officers to familiarize themselves with the community facilities—the private physicians who treat alcoholics, the clinics, and the Alcoholics Anonymous groups in the area. The best sources for this kind of information are the local alcoholism information centre and the local AA office, both of which are generally listed in the telephone directory. If the area does not have an active alcoholism council, a note to the National Council on Alcoholism in the United States or the provincial alcoholism program in each Canadian province will bring assistance.

Union sources of help

Union officers who need help with a member who has a drinking problem can also consult the AFL-CIO Community Services Department, which has considerable information available and can also recommend local sources of help in many areas.*

In addition, many university and community groups throughout the country conduct seminars designed to provide guidance in dealing with alcoholics. The best known of these schools are the Rutgers Summer School, held on the campus of Rutgers University, the Southeastern School of Alcohol Studies at the University of Georgia, and the summer school of the Ontario Addiction Research Foundation.

Many international unions, on their own initiative, have instituted training programs for their stewards. These programs, which often cover a wide range of health-related problems, have been particularly effective in informing union officers about alcoholism, making them more sensitive to the

*The Canadian Labour Congress has no counterpart to the AFL-CIO Community Services Department insofar as alcohol problems are concerned, but Canadian officers of unions affiliated with the AFL-CIO can request the help of this department through the international offices of their own unions.—*Ed.*

early signs of the disorder, and charting a course of action in dealing with alcoholic employees. AFL-CIO Community Service groups have also operated successful community-wide training programs which accomplish the same objective.

In short, there are many community and union sources from which the interested union officer, on his own and without any formal program, can obtain information about what to do when confronted with an alcoholic employee.

Where management has a unilateral program, the union can make several important contributions to it. In the first place, since the steward works in day-to-day contact with the employees, he is in an excellent position to identify an alcoholic. He is also in an excellent position to exert pressure on the alcoholic to seek the kind of help he needs. Because of the steward's close personal relationship with the alcoholic, he can talk with him on a man-to-man basis and get him to go to treatment. The steward can also point out to the alcoholic's wife the necessity for constructive action. Thus the steward can catch the alcoholic before his problem reaches the stage of company involvement.

If the steward backs the program

The steward can also perform a valuable function as a source of information about the company program. If the steward backs the company program and "sells" it to his membership, the program is likely to receive considerably more employee support. In the eyes of the employees, information that comes from the union may well be more believable than the same information from the company. So, by talking up and explaining the company program, the steward can do a great deal to further the program's objectives.

When an alcoholic union member has refused the aid offered informally by the steward and is confronted by the company for work deficiencies that flow from his illness, the steward can join with management in confronting the alcoholic. By reinforcing the need for treatment and closing one

avenue of escape for the alcoholic, the union can add to the effectiveness of the company's constructive-coercion policy. As one steward said, "we can convince the alcoholic that the company really means business and he had better get down to the clinic regularly."

How the steward can help

If the alcoholic does accept treatment, the steward is in a position to provide aid and counsel to the alcoholic and his family. Because the steward is on friendly terms with the family, he can give a sympathetic ear to their problems and help them through a difficult time. In addition, the steward can provide a valuable link between the alcoholic and his place of work. While the alcoholic is in treatment, the steward can give him emotional support and help him to face the difficult task of reclaiming his job and regaining the support of his fellow workers. The steward can also be a potent figure in persuading the recovered alcoholic's fellow workers to accept him back into the group.

Where the union runs the alcoholism program on its own, there are a number of things it can do to make that program more successful. In the first place, the union can enlist the aid of a variety of community agencies that will give help and advice at no cost. This advice ranges from how to spot an alcoholic to how to run a clinic. Prime sources of help are the local Community Chest, Social Planning Council, Alcoholism Council, Mental Health Council, or Medical Society.

Secondly, the union might well consider appointing one of its "dry" alcoholic members to run the alcoholism program. Such a man is in a very good position to understand the problems of alcoholics and the kind of help they need. In addition, he is likely to be aware of the facilities in the community that are available to help alcoholics. The use of the "alcoholic counsellor" is very popular, and has been successful in many areas.

Whoever runs the program for the union must receive ade-

quate training in the problem of alcoholism and in ways of helping the alcoholic. Community agencies such as the Alcoholism Council or the Medical Society can be very helpful in this regard.

It is also important for the director of the program to remain abreast of developments in this area. Membership in groups such as the North American Association of Alcoholism Programs, and attendance at conferences on alcoholism, can be of great assistance.

Once the union has appointed and trained a man to run its alcoholism program, it is important that he conduct an educational program with union leaders, stewards, and the rank and file to build understanding and cooperation. AFL-CIO Community Service groups can be of great assistance in securing training material.

A cooperative program

A joint union-management program holds the most promise for effective handling of alcoholism in industry. There are essentially three steps that can be taken to overcome the problems described earlier. First of all, the company must secure union participation during the planning stages of any program. If the union is not allowed to take part in shaping the program, union support will be hard to obtain later on.

Secondly, training and education programs are necessary to combat insufficient knowledge at the lower levels of the union—the stewards and the rank and file. These programs should stress the broader mental-health aspects of inconsistent and poor performance, the progressive nature of alcoholism, and the availability of treatment facilities. The training must be aimed at attitudinal change—at lowering the steward's tolerance for alcoholic absenteeism and inefficiency, thus bringing on an earlier crisis for the alcoholic and increasing his chance of rehabilitation. The seminars and information centres mentioned earlier would be especially valuable to stewards and other union officers taking part in the program.

Thirdly, and most importantly, the key role the steward can play must be recognized. Tying the steward in to the program—making him the link between the alcoholic, his family and his job—increases the chance of early referral and easy “re-entry.”

There are a number of other steps that a union can take to make a joint union-management program work. First of all, cooperation with management in other areas—safety, community fund-raising and other mutual concerns—undoubtedly helps the prospects for an effective joint alcoholism program. Cooperation is contagious. Secondly, if the union is to make a real contribution to the joint effort, the rank-and-file members as well as the stewards must be educated in the problems of alcoholism.

Communication within the union

Thirdly, good communication within the union structure is an absolute necessity. Often communication gaps develop between the senior union officers who took part in setting up the joint program and the junior officers who did not. There is a natural mistrust between the stewards and other officers at the local level and those at the regional level, and the alcoholism program can divide them still further. The union officers who participate in the program must constantly be aware of the need to keep the steward informed on cases in which he has played a part. In fact, some regular feedback on “how John is getting along” is probably the best way of keeping the steward involved in the program.

Finally, as we have pointed out earlier, the union leader must be on his guard that his understanding of management’s problems does not lessen the militancy with which he presses for the needs of the union members. It is too easy to slip into the easy way out, and a genuinely militant or a dissident group in the local can make it a very expensive slip.

All in all, we are optimistic about the possibilities for active and constructive union involvement in alcoholism programs.

It is only through union-management cooperation that industry can effectively deal with this major health problem.

[Un programme industriel de lutte contre l'alcoolisme peut être réalisé, soit par la direction seulement, soit par le syndicat seulement, soit en coopération par la direction et le syndicat. Les auteurs examinent les avantages et les désavantages inhérents à ces diverses situations, et le rôle que le syndicat peut jouer dans chacune d'elles. Une action combinée semble être la meilleure méthode, mais de nombreux dirigeants syndicaux craignent qu'une coopération avec la direction puisse compromettre le rôle traditionnel du syndicat en tant que défenseur de l'employé. Cette crainte est le plus grand obstacle à une coopération efficace, de la part des syndicats, aux programmes industriels de lutte contre l'alcoolisme.]

Au verso:

Les auteurs ont étudié les hippies du quartier de Haight-Ashbury à San Francisco et ont découvert qu'une distinction se faisait jour entre deux groupes différents de hippies: les "heads" et les "freaks". Au niveau de définition le plus simple de ces termes, un "head" est un usager régulier de LSD, alors qu'un "freak" est une personne qui se fait des injections de méthédrine. Cependant, cette distinction ne repose pas seulement sur le choix de différentes drogues: les individus des deux groupes appartiennent à des couches sociales différentes, ils diffèrent par leur attitude, leur philosophie et leur genre de vie. Ces différences font naître des tendances discordantes au sein de la "sub-culture" hippy, aggravant ainsi les problèmes auxquels cette sub-culture fait déjà face.

Heads and Freaks:

Patterns and Meanings of Drug Use Among Hippies

By Fred Davis, Ph.D., with Laura Munoz, M.Sc.

Regardless of whether the phenomenon is viewed in terms of a bohemian subculture, a social movement, a geographically based deviant community or some combination of these, there is substantial agreement among those who have studied hippies (Berger, 1967; Davis, 1967; Didion, 1967; Simon and Trout, 1967; von Hoffman, 1967) that drugs (or "dope," the term preferred by hippies)¹ play an important part in their lives. This generalization applies to nearly all segments of the hippie community for the reasons given below.

First, the patent empirical fact of widespread and frequent drug use *per se*² is easily ascertainable through even a brief stay in San Francisco's Haight-Ashbury, New York's East Village, Los Angeles' Fairfax, Vancouver's Fourth Avenue or wherever else hippie colonies have sprung up.³

The hippie philosophy on drugs

Second—and this importantly distinguishes hippie drug use from that of other drug-using subcultures—there are pronounced ideological overtones associated with it. Not only is it frequently asserted by many hippies that there is "nothing wrong" with certain of the drugs favored by them (chiefly marijuana and LSD, along with a number of other hallucinogens), or that their use is less harmful than alcohol or tobacco,⁴ but that these drugs are positively beneficial, either as a pleasant relaxant, as with marijuana, or as a means for

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gaining insight with which to redirect the course of one's life along inwardly more satisfying and self-fulfilling lines (LSD).

Among other manifestations, this spirit of ideological advocacy expresses itself in the conviction of some hippies that their ultimate social mission is to "turn the world on"—i.e., make everyone aware of the potential virtues of LSD for ushering in an era of universal peace, freedom, brotherhood and love.

Facts of life in the subculture

The last, and perhaps most crucial, circumstance for making drug use important in the lives of hippies is the simple and stark matter of the drugs' illegality. As contemporary deviance theory of the symbolic interactionist persuasion has shown in so many differing connections (Becker, 1963; Davis, 1961; Freidson, 1965; Goffman, 1963; Kitsuse, 1961; Lemert, 1962), the act by a community of successfully labeling a particular practice deviant and/or illegal almost invariably constrains the "deviant" to structure much of his identity and activity (Strauss, 1959) in terms of such imputations of deviance and law-breaking.

Thus, the omnipresent threats of police harassment, of arrest and incarceration, as well as of a more diffuse social ostracism, are "facts of life" which the hippie who uses drugs only occasionally must contend with fully as much as the regular user.

Beyond these rather global observations, all further generalizations concerning hippie drug use must be qualified carefully and treated as tentative. For not only are the actual patterns of drug use quite varied among individual hippies and different hippie sub-groups, but the patterns themselves are constantly undergoing change as the subculture evolves and gains greater experience with drugs (Becker, 1967). Further compounding the hazards of facile generalization are the following:

1. The apparent readiness of many hippies to experiment—if only once “to see what it’s like”—with almost any drug or druglike substance, be it Hawaiian wood rose seeds, opium or some esoteric, pharmacologically sophisticated psychoactive compound.

New fashions in drugs

2. The periodic appearance on the hippie drug market of new drugs, usually of the hallucinogenic variety, which, like new fashions generally, excite a great flurry of initial interest and enthusiasm until they are either discredited, superseded or partially assimilated into a more “balanced” schedule of drug use. Thus, in the past year alone, for example, at least three new hallucinogenic type drugs have made much-heralded, though short-lived, appearances in the Haight-Ashbury: STP (dimethoxymethyl-amphetamine), MDA (methylene-dioxy-amphetamine) and PCP, the “peace pill” (phencyclidine).

3. The vagaries, uncertainties, deceptions and misrepresentations of the illegal drug market as such. Not only is it hard for a buyer to be sure that he is getting the drug he thinks he is getting—indeed, that he is getting any drug at all and not some placebo—but dosages, strengths and purity of compounding, even when not knowingly misrepresented by dealers, are likely to be unknown or poorly understood by dealer and buyer alike.⁵ Thus, the ubiquitous possibility of an untoward reaction in which the user, or a whole aggregate of users, becomes violently ill or severely disoriented.

4. The fact, to be discussed later, that the very same drug (LSD, for example) can, depending on the intent of the user, his mood, the setting and the group context, be used to achieve very different drug experiences and subjective states. Though this “choice of drug experience” is never fully within the control of even the experienced user (see 3, above), it does exist, and thus facilitates differential use by different users as well as by the same user at different times.

Obliquely, these circumstances point to what is perhaps the chief obstacle to making firm generalizations concerning hippie drug use, namely, that the subculture is not (at least as yet) of a piece, that it includes many disparate social elements and ideational tendencies (Davis, 1967; Simon and Trout, 1967) and that, to the extent that drug use constitutes something of a core element in it, this must be seen in the context of these varying and constantly shifting socio-ideational subconfigurations.

As has been characteristic of almost any expressive social movement in its formative stages (cf. Blumer, 1946), this diversity in the midst of a search for common definition is reflected in the frequent discussions among hippies on who is a "real" hippie, who a "plastic" hippie, and what "genuine" hipness consists of. Moral, behavioral and attitudinal boundaries of inclusion and exclusion are constantly being assessed and redrawn. But, in the absence of any recognized leadership group capable of issuing *ex cathedra* pronouncements on these matters, one man's, or one underground paper's, definition is as good as the next's.

Attitudes towards drug use

These ongoing discussions, debates and polemics extend, of course, to the place and use of drugs in the "new community," as hippie spokesmen like to refer to themselves. Some take a very permissive and inclusive stance, others a more restrictive one, and still others shift their ground from one encounter to the next. Inconclusive as this dialogue may be from an organizational standpoint, it nonetheless is important for the influences, albeit variable, it exerts on drug practices and attitudes within the subculture.

With these reservations in mind we wish to sketch here a rough sociological atlas, as it were, of patterns and meanings of drug use among San Francisco's Haight-Ashbury hippies, at least insofar as these manifested themselves through the summer and well into the fall of 1967. The data were gathered

by the methods of ethnographic field work as part of a broader study of the interaction of Haight-Ashbury's hippie community with the larger San Francisco community.

Although informed by a close-in familiarity with the hippie community, the data are, strictly speaking, impressionistic inasmuch as time, resources and certain situational peculiarities connected with doing research among hippies⁶ militated against any exhaustive study of drug use *per se*.

LSD and Methedrine

Since much of what follows deals with social psychological aspects of the use of the above two drugs, a few preliminary words are in order concerning the drugs themselves, their direct pharmacological effects, average dosages, modes of administration and frequency of use. No detailed description can be attempted here (see Blum, 1964; Kramer *et al.*, 1967); rather, our aim is merely to touch on a few matters pertinent for the subsequent discussion of types of drug users.

Inasmuch as we shall not be discussing marijuana, suffice it to say here that it is very widely used by all segments of the hippie community and constitutes the drug staple of the subculture. (Hashish, the purified and condensed form of cannabis, though much preferred by those who have tried it appears in the Haight-Ashbury only rarely and commands an exceedingly high price.)

LSD dosages vary

The hallucinogenic LSD (lysergic acid diethylamide), one of a growing family of such drugs, is marketed in the Haight Ashbury in tablet form. The shape, color and general appearance of tablets will vary considerably, from "well made" to "extremely crude," as new batches are produced by different illegal manufacturers. Taken orally, an average dose usually one tablet, contains approximately 185 micrograms of LSD. Some users, though, are known to ingest considerably more than this amount, i.e., up to 1,000-1,250 micrograms

when they wish to "turn on." Street prices vary from about \$2.50 per tablet in times of plentiful supply to \$5.00 and \$6.00 when supply is short.

Typical users in the Haight-Ashbury "take a trip" once a week or thereabouts on the average; again, however, there is a considerable number who "drop acid" much more frequently, perhaps every three or four days, while still others resort to the drug only occasionally or episodically. The characteristic psychopharmacologic effects of the drug are described by Smith (1967:3) as follows:

When someone ingests an average dose of LSD (150-250 micrograms), nothing happens for the first 30 or 45 minutes, and then after the sympathetic response the first thing the individual usually notices is a change in the way he perceives things. . . . Frequently . . . he notices that the walls and other objects become a bit wavy or seem to move. Then he might notice colors . . . about the room are looking much brighter or more intense than they usually do and, in fact, as time goes on these colors can seem exquisitely intense and more beautiful than any colors he has seen before. Also, it is common for individuals to see a halo effect around lights, also a rainbow effect. . . . There is another kind of rather remarkable perceptual change, referred to as a synesthesia. By this I mean the translation of one type of sensory experience into another, so that if one is listening to music, for example, one can sometimes feel the vibrations of the music in one's body, or one can sometimes see the actual notes moving, or the colors that he is seeing will beat in rhythm with the music.

More pronounced effects of an emotional, meditative or ratiocinative kind can, but need not, follow in the wake of these alterations in sense perception. In any case, the direct effects of the drug last on the average for an eight to twelve hour span.

Methedrine (generic name, methamphetamine) is a stimulant belonging to the sympathomimetic group of drugs. Its appearance is that of a fluffy white powder, referred to commonly as "crystal." In the Haight-Ashbury it is sold mainly in spoonful amounts (1-2 grams, approximately) and packaged in small transparent envelopes, prices ranging from \$15.00 to

\$20.00 an envelope. Frequently, a user or small dealer in need of cash will repackage the powder and sell it in smaller amounts.

Until a few years ago most users of Methedrine took it orally in capsule form. Among Haight-Ashbury hippies, however, the primary and preferred mode of administration is intravenous injection. Hence, the paraphernalia employed is almost identical to that of the heroin user: hypodermic needle, syringe, spoon for diluting the powder in tap water, and candle for heating the mixture.

Effects of Methedrine

Because needles and associated equipment are often unsterilized or poorly sterilized, cases of serum hepatitis are quite common among Methedrine users. The physiological effects of the drug are elevated blood pressure, increased pulse rate, dilation of pupils and blurred vision—these accompanied by such behavioral states as euphoria, heightened spontaneous activity, wakefulness, loss of appetite and, following extended use, suspicion and acute apprehensiveness (“paranoia”).

Although there is some disagreement among experts on whether regular use of Methedrine leads to addiction as, for example, in the case of heroin, it is well-established that a fair proportion of users become extremely dependent on the drug. Thus, whereas the episodic user will inject 25-50 milligrams for a “high,” those who get badly “strung out” on a two-to-three-week Methedrine binge will by the end be “shooting” as frequently as six times a day for a total daily intake of some 1,000 to 2,000 milligrams (1 to 2 grams). Needless to say, were it not for the steep increase in body tolerance levels built up through continuous use of the drug, such high daily dosages might well prove lethal.

A suitable starting point for our ethnographic sketch is those terms and references used by hippies themselves to distinguish certain types of drug users and patterns of drug use. Chief among these is the contrast drawn between “heads”

and "freaks," sometimes explicitly, though more often implicitly with reference to a particular drug user or drug practice. While a whole penumbra of allusive imagery surrounds these terms, a "head" essentially is thought to be someone who uses drugs—and, here, it is mainly the hallucinogens that the speaker has in mind—for purposes of mind expansion, insight and the enhancement of personality attributes, i.e., he uses drugs to discover "where his head is at."

For the "head," therefore, the drug experience is conceived of, much as during the first years of LSD experimentation by psychiatrists and psycho-pharmacologists (ca. 1956-1963), as a *means* for self-realization or self-fulfillment, and not as an end in itself. The term, "head," is, of course, not new with hippies. It has a long history among drug users generally, for whom it signified a regular, experienced user of any illegal drug—e.g., pot "head," meth "head," smack (heroin) "head." Although still sometimes used in this non-discriminating way by hippies, what is novel about their usage of "head" is the extent to which it has become exclusively associated with certain of the more rarified facets of the LSD experience.

Who is a "freak"?

By contrast, the term "freak" refers usually to someone in search of drug kicks as such, especially if his craving carries him to the point of drug abuse where his health, sanity and relations with intimates are jeopardized. Though used primarily in the context of Methedrine abuse ("speed freak"), the reference is frequently broadened to include all those whose use of any drug (be it Methedrine, LSD, marijuana or even alcohol) is so excessive and of such purely hedonistic bent as to cause them to "freak out," e.g., become ill or disoriented, behave violently or erratically, give evidence of a "paranoid" state of mind.

Whereas the primary connotative imagery of "head" and "freak" derives mainly from the subculture's experience with drugs, the terms themselves—given their evocative associa-

tions—have in a short course of time acquired great referential elasticity.

Thus “head,” for example, is extended to include any person (hip, “straight,” or otherwise) who manifests great spontaneity, openness of manner, and a canny sensitivity to his own and others’ moods and feelings. Indeed, hippies will claim that it is not strictly necessary to use hallucinogenic drugs—helpful though this is for many—to become a “head” and that, moreover, there are many persons in the straight world, in particular children, who are “really heads,” but don’t know it.

The “secret union” concept

Parenthetically, it might be noted that the concept of a *secret union* of attitude and sensibility, including even those ignorant of their inner grace, is a familiar attribute of expressive social movements of the deviant type; among other purposes, it helps to subjectively legitimate the proselytizing impulses of the movement. Homosexuals, too, are known to construct such quasi-conspiratorial versions of the world.

Similarly, the term “freak,” while much less fertile in its connotative imagery than “head,” is also extended to persons and situations outside the immediate context of drug use. Hence, anyone who is too aggressive or violent, who seems “hung up” on some idea, activity or interactional disposition, might be called a “freak.” Accordingly, abnormal phases (e.g., high anxiety states, obsessiveness, intemperateness) in the life of one customarily thought a “head” will also be spoken of as “freaking” or “freaking out.”

The two terms, therefore, have acquired a quality of idealtypicality about them in the hippie subculture and have, at minimum, come to designate certain familiar social types (cf. Strong, 1946). At this level of indigenous typifications, they can be seen to reflect certain ongoing value tensions in the subculture: a reflecting turning inward versus hedonism, Apollonian contentment versus Dionysian excess, a millennial

vision of society versus an apocalyptic one. And that these generic extensions of the terms derive so intimately from drug experiences affords additional evidence of the symbolic centrality of drugs in the hippie subculture.⁷

In the more restrictive, strict drug-using sense, who, then, are "heads" (LSD or "acid" users) and who "freaks" (Methedrine or "speed shooters")?

Lacking accurate demographic data on the subject, our impression is that "heads" are found more often among the older, more established and less transient segments of the Haight-Ashbury hippie community, i.e., persons of both sexes in their mid-to-late twenties who, while not exactly holding down full-time jobs of the conventional sort, are more or less engaged in some regular line of vocational activity: artists, craftsmen, clerks in the hippie shops, some hippie merchants, writers with the underground press, graduate students, and sometimes mail carriers, to mention a few. It is mainly from this segment that such spokesmen and leaders as the "new community" has produced have come.

Where "freaks" are found

By comparison, "freaks" are found more often among the more anomic and transient elements of the community, in particular those strata where "hipness" begins to shade off into such quasi-criminal and thrill-seeking conglomerates as the Hell's Angels and other motorcyclists (known locally as "bikeies"), many of whom now frequent the Haight-Ashbury and have taken up residence in and around the area.

Some observers even attribute the growing use of Methedrine to the fact that it and closely related stimulants (e.g., Benzedrine, Dexedrine) were popular with West Coast motorcycle gangs well before the origins of the hippie community in the Haight-Ashbury. Unlike "acid," which is widely used by both males and females, "speed" appears to be predominantly a male drug.⁸

As these observations would suggest, it is our further

impression that "heads" are by and large persons of middle and upper-middle class social origins whereas "freaks" are much more likely to be of working class background. Despite, therefore, the strong legal and moral proscriptions against both LSD and Methedrine, their differential use by hippies reflects, at one level at least, the basic contrast in expressive styles extant in the American class structure; put crudely, LSD equals self-exploration/self-improvement equals middle class, while Methedrine equals body stimulation/release of aggressive impulses equals working class.

Distinction only approximate

These characterizations, however, afford but a gross approximation of drug use patterns in the Haight-Ashbury. The actual demography of use is complicated considerably by a variety of changing situational and attitudinal currents, some of which were alluded to earlier.

Two additional matters especially deserve mention here. The first is the existence of a large, socially heterogeneous class of mixed drug users: persons who are neither "heads" nor "freaks" in any precise sense, but who regularly sample both LSD and Methedrine, as well as other drugs. Shifting intermittently or episodically from one to another, they may, save for continued smoking of marijuana, even undergo extended periods of drug abstinence. Of such users it can, perhaps, best be said that the very absence of any consistent pattern is the pattern.

Secondly, it should be noted that this non-pattern pattern of drug use (this secondary anomie within a more inclusive deviant life scheme) has grown more pronounced in the Haight-Ashbury in recent months. Whereas prior to the summer of 1967 a newly arrived hippie would in all probability have been socialized into the LSD users' culture of "tripping," "mind-blowing" and meditation—"heads" then clearly constituted the socially, as well as numerically, dominant hippie group in the area—this kind of outcome became

a good deal less certain following the publicity, confusion, congestion and increased social heterogeneity of recruits that attended the summer influx of youth from across the country (Davis, 1967).

Not only did many of the settled hippies move away from the area in the wake of this massive intrusion, but new styles and tastes in drug use, notably "speed shooting," quickly established themselves. With the inundation and dispersal of the older "head" group, it became largely a matter of sheer fortuitousness whether a novice hippie turned to "acid" or "speed," to some other drug or a combination of several. Whose "pad" he "crashed" on arrival or who befriended him the first time he set foot on Haight Street could have as much to do with his subsequent pattern of drug use as anything else.

This was conspicuously so in the instance of younger recruits, many of them runaways from home in the 14-17 age group, who, except perhaps for marijuana smoking, were completely naive to and inexperienced in drug use.

"Head" is a compliment

Nonetheless, to the extent that the hippie subculture has managed to conserve elements of a core identity and to develop something of a common stance vis-à-vis "straight" society, it is still the "head" pattern of drug use that is ideationally, if not necessarily numerically, dominant within it. Thus, to be spoken of as a "head" is complimentary, whereas to be termed a "freak" or "speed freak" is, except in certain special contexts, derogating.

Similarly, the underground press is forever extolling the virtues of "acid"; but, apart from an occasional piece of somewhat patronizing tone in which the author tries to "understand" what "gives" with Methedrine users (Strauss, 1967), it almost invariably condemns "speed." Numerous posters on display in the Haight Street print and funny button shops announce in bold captions "SPEED KILLS."

The perceived dichotomy between mind-expansion and

body-stimulation represented by the two drugs is sometimes reconceptualized to apply to LSD users alone, so as to draw a distinction between those who use the drug mainly for purposes of "tripping" as against "true" or "real" "heads" who purport to use it for achieving insight and effecting personality changes within themselves.

Set and setting

While dosage levels of the drug seem to play some part in determining whether a "tripping" or "mind-expanding" experience will ensue—the larger the dose, the more likely the latter or, alternatively, a "bum trip," i.e., a panic reaction with severe disorientation—the intent and setting of the user also appear to have an important bearing on the outcome. Quiet surroundings, a contemplative mood and interesting objects upon which to focus (e.g., a mandala, a candle flame) are felt to be conducive to a mind-expanding experience; moving street scenes, an extroverted mood and the intense visual and auditory stimuli of the typical folk-rock dance and light show are thought conducive to "tripping."

In any event, he who uses LSD only to "trip" (i.e., to intensify and refract his sensate experience of the environment) is regarded, at best, with a certain amused tolerance by "righteous acid heads." The latter, therefore, frequently counsel beginning users of LSD to move beyond mere "tripping" to where they can realize the higher meditative, revelatory and religious potentials of the drug.

In this connection, a number of hippie groups, particularly those involved in the Eastern religions, advocate dispensing with LSD and other hallucinogens altogether following realization of these higher states; once the "doors of consciousness" have been opened, it is stated, it is no longer necessary to use drugs for recapturing the experience—newly discovered powers of meditation alone will suffice. Be that as it may, because the "head"—as both a certain kind of drug user and a certain kind of human being—has emerged as the model

citizen of the hippie movement, there are many who aspire to the status and aim to follow the true path that can lead them there.

In sum, drug use among Haight-Ashbury hippies reveals a number of contrary tendencies, the chief being the emergent social and symbolic contrast of the "head" and "freak" patterns—a contrast which, as we have seen, encompasses cultural elements well beyond the immediate realm of drug use *per se*. While the two patterns can, though several analytical levels removed, be traced back ultimately to certain historically persistent, subterranean expressive value strains in American society-at-large (see Matza, 1964), their surfacing and intimate co-existence within the hippie subculture serve to aggravate already difficult problems of member socialization, group integration and ideology that confront the community (Davis, 1967).

Stated otherwise, the process of community formation is hindered, not wholly, or even primarily, by outside forces of repression—for these will often solidify a social movement—but through the generation of anomie from within as well.

Subculture open to predators

If illegal and socially condemned drug use did not play so large a part in the subculture, these divisive tendencies could, perhaps, be better contained. As is, however, the pervasiveness of illegal drug use constantly opens up the subculture to a gamut of socially disparate, unassimilable elements and assorted predators, few of whom share the ethos of love, expressive freedom and disengagement from narrow materialistic pursuits that animated, and still animates, many within the movement. And, since it is highly unlikely that the drugs favored by hippies (again, possibly excepting marijuana) will soon be made legal, this situation is likely to get worse before it gets better.

As to the drug use patterns themselves, it can only be a matter of conjecture as to which—"head" or "freak"—if

either, will come eventually to clearly prevail in the hippie community. Although the "head" pattern appears on the face of it to resonate more deeply with those broader philosophical and ideational themes that distinguish the movement,⁹ it has, in the Haight-Ashbury at least, already lost much ground to the more exclusively hedonistic "freak" pattern. Should it continue to do so, what did have the earmarks of a culturally significant expressive social movement on the American scene could easily dissolve into little more than the sociologist's familiar "drug users' deviant subculture."

Notes

¹As with earlier expressive social movements of a religious tendency it is characteristic of hippies to employ, and thereby semantically reconstruct for initiates, a discredited term of pungent reference where, on purely denotative grounds, a more "acceptable" one would do as well or even better. The frequent public resort to sexual and scatological profanity by hippies (see Berger, 1967), most of whom were raised in homes where the use of such words would, to say the least, be frowned upon, is further evidence of this all but conscious tendency to linguistically celebrate the rejected and despised so as to cast them in a new moral light. Compare the remarks of Kenneth Burke (1954:125-147) on "organized bad taste."

²This, of course, is not to say that drug use (and abuse) is not widespread among Americans generally. Rather, the obvious point is that the alcohol, tranquilizers, barbiturates, stimulants and common pain-relievers used in conventional society have not, despite the known injurious effects of some of them, been officially declared illegal or detrimental to health and morals as have the drugs favored by hippies. Hence, they are, except in extreme instances of abuse, treated as part of the everyday, taken-for-granted world of pharmaceutical products and household remedies to which little, if any, stigma is attached. Hippies, naturally, are forever pointing this out in their continuing campaign for drug law reform. "Why condemn us, when so many of you are constantly turning to drugs for almost every conceivable contingency of daily life? What makes your drug 'abuse' any better than ours?"

³Exception must be made for a small number of hippie communes and settlements, most of them in rural areas, where, according to reports in the underground press, the use of all mind and mood-altering drugs is disapproved of.

⁴As far as tobacco is concerned, the point is largely gratuitous. Our impression is that a great many hippies are heavy cigarette smokers.

⁵A useful discussion of the hippie drug market—manufacture of drugs, distribution, pricing, types of drug dealers, relations with buyers, etc.—would require a lengthy paper in itself. Two points in particular, however, deserve mention here for the special interest they hold for sociologists. 1) Much as in the legitimate drug trade, new drugs like STP and MDA are introduced selectively at first by manufacturers' and/or distributors' "detail men" making free samples available to the drug cognoscenti and opinion leaders in the hippie community (cf. Coleman *et al.*, 1966). If favorably received in these elite circles, the drug is then put on the street market for "open" sale. 2) In line with the anti-hoarding sentiments of hippies, it is regarded as bad form not to share a "good thing," especially when one has a surplus on hand. It is not uncommon then, for hippie drug dealers, particularly non-commercial ones who only trade casually to earn a bit of extra cash, to give away gratis a fair portion of their stock to friends and favorites.

⁶Above and beyond understandable sensitivities relating to illegal drug use, many hippies resent and deplore conventional modes of sociological inquiry—questionnaires, schedules, formal interviews, etc.—directed at them. These, they state, reduce the respondent to a "thing," a mere statistical instance in an artificially constructed class of events, thereby denying him his individuality and possibilities for creative being. In line with certain prominent strains in the hippie ethos, the feeling is that it is never humane or just to relate to another in these terms. Tied in with these sentiments is the not wholly unfounded conviction of certain more sophisticated hippies that social science investigators who do research among them are interested primarily in furthering their own careers; they "take" from the "new community" and return nothing to it by way of aid or comfort.

Much as these attitudes make for difficulties in conducting research among hippies, they have the virtue of posing in a sharp and decidedly concrete manner a number of largely unexamined ethical, and epistemological, issues underlying social science research on human groups. See Bruyn 1966; Seeley, 1967; Sjoberg, 1967.)

⁷Similarly, hippie art, poetry and folk-rock music are often appraised in terms of their "druggy" qualities, i.e., how nearly they evoke the moods and sensations associated with drug experiences.

⁸Some preliminary survey data gathered by Professor Frederick H. Meyers of the University of California Medical Center, San Francisco, suggest, however, that the ratio of female Methedrine users

(and abusers) among hippies is significantly higher than is commonly thought to be the case.

⁹In this connection, a case could be made, and is by some hippies, that much which is distinctive about the hippie subculture (e.g., its music, aversion to physical violence, return to nature, communal sharing, etc.) are the product of the "acid" experience rather than psycho-cultural determinants of it. That is to say, the direct psychopharmacologic effects of LSD are such as to lead people to selectively reconstitute their inner world of memory, feeling, percept, attitude, etc., in a new and *particularistic* way—in this instance a kind of Apollonian reconstruction of social reality.

If true, this opens up the interesting and frightening Huxleyan possibility of drugs not merely regulating culture but, in an important sense, generating it as well. Also, if true, this would call for certain qualifications in Becker's (1967) proposed thesis that it is the users' subculture, and not the direct effects of the drug *per se*, which largely determine the meaning and ideational content of the drug-induced experience.

References

- BECKER, HOWARD S. *Outsiders*. New York: Free Press, 1963.
- . History, Culture and Subjective Experience: An Exploration of the Social Bases of Drug-Induced Experiences. *Journal of Health and Social Behavior*, 8 (163-176), September, 1967.
- BERGER, BENNETT M. Hippie Morality—More Old than New. *Trans-action*, 5 (19-27), December, 1967.
- BLUM, RICHARD H., and Associates. *Utopiates: The Use and Users of LSD-25*. New York: Atherton, 1964.
- BLUMER, HERBERT. Collective Behavior. In A. M. Lee (ed.), *New Outline of the Principles of Sociology* (199-221). New York: Barnes and Noble, 1946.
- BURKE, KENNETH. *Permanence and Change*. Los Altos, Calif.: Hermes, 1954.
- BRUYN, SEVERYN T. *The Human Perspective in Sociology*. Englewood Cliffs, N.J.: Prentice-Hall, 1966.
- COLEMAN, JAMES S.; KATZ, ELIHU; and MENZEL, HERBERT. *Medical Innovation, A Diffusion Study*. Indianapolis: Bobbs-Merrill, 1966.
- DAVIS, FRED. Deviance Disavowal. *Social Problems*, 9 (120-132) Fall, 1961.
- . Why All of Us May Be Hippies Someday. *Trans-action*, 5 (10-18), December, 1967.
- DIDION, JOAN. The Hippie Generation. *Saturday Evening Post*, Sept 23, 1967.

- FREIDSON, ELIOT. Disability as Social Deviance. In M. B. Sussman (ed.), *Sociology and Rehabilitation* (71-99). Washington: American Sociological Association, 1965.
- GOFFMAN, ERVING. *Stigma*. Englewood Cliffs, N.J.: Prentice-Hall, 1963.
- KITSUSE, JOHN I. Societal Reaction to Deviant Behavior. *Social Problems*, 9 (247-256), Winter, 1962.
- KRAMER, JOHN C.; FISCHMAN, VITEZSLAV S.; and LITTLEFIELD, DON C. Amphetamine Abuse. *JAMA*, 201 (305-309), July 31, 1967.
- LEMERT, EDWIN. Paranoia and the Dynamics of Exclusion. *Sociometry*, 25 (2-20), March, 1962.
- MATZA, DAVID. Position and Behavior Patterns of Youth. In R. E. L. Faris (ed.), *Handbook of Modern Sociology*. Chicago: Rand McNally, 1964.
- REELEY, JOHN. *The Americanization of the Unconscious*. Philadelphia and New York: International Science Press, 1967.
- SIMON, GEOFFREY, and TROUT, GRAFTON. Hippies in College—From Teeny-Boppers to Drug Freaks. *Trans-action*, 5 (27-32), December, 1967.
- SJOBERG, GIDEON (ed.). *Ethics, Politics and Social Research*. Cambridge, Mass.: Schenkman, 1967.
- SMITH, DAVID E. Lysergic Acid Diethylamide: An Historical Perspective. *Journal of Psychedelic Drugs*, 1 (2-7), Summer, 1967.
- STRAUSS, ANSELM L. *Mirrors and Masks*. Glencoe, Ill.: The Free Press, 1959.
- STRAUSS, RICK. Confessions of a Speedfreak. *Los Angeles Oracle*, 1, July, 1967.
- TRONG, SAMUEL M. Negro-White Relations as Reflected in Social Types. *American Journal of Sociology*, 52 (23-30), July, 1946.
- AN HOFFMAN, NICHOLAS. Dope Scene—Big Business in the Haight. *San Francisco Chronicle*, October 31, 1967.
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Alcohol as Medicine

"There's nothing like a drop of whisky to cure your 'flu'." Words to that effect—with a "grog" or a brandy taking the place of whisky from one country to another—have been staples of popular medicine for centuries. A few years ago, members of the French *Académie de médecine* decided to try to prove the truth or falsehood of such assertions and conducted a number of tests on the action of alcohol on the viruses causing influenza and other related diseases. Their study showed that alcohol had absolutely no direct beneficial action on the influenza virus—or any other—and cannot therefore be counted upon either to protect individuals from infection or to halt the spread of an epidemic. These studies, and a number of others over the years, showed, too, that heavy drinkers are less resistant to the onslaught of virus infections than more temperate individuals. Still, the fact remains that some cold or "flu" victims do seem to feel better after drinking a hot toddy. Even if they have not done anything directly about their disease, their temporary feeling of well-being may have two causes. In the first place, the alcohol, as an anaesthetic agent, may dull their aches and pains temporarily. Secondly, if the patient really believes that a hot toddy will make him feel better, the psychological action may have some effect on his general feeling of well-being, even if it hasn't done a thing to help him physically.

—From *World Health*, the magazine of
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A.I.T. Addictions

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When Whisky Went Round With the Waltz

By Margaret K. Ziemann

What exactly is social drinking? How much drink, for one thing, does it involve? It does of course suggest moderation in drinking, but moderation is an elastic term and can vary with the individual, with different social classes—and it certainly has varied with the times. Back in pioneer Upper Canada of 1835, a man was considered a moderate drinker if he did not exceed four glasses of liquor a day. And liquor then meant raw whisky, drunk straight. It sold for 50 cents a gallon.

Many who deride the temperance movement as a hoary relic of an earlier period, a throwback to our somewhat puritanical ancestors—certainly not in keeping with today's emphasis upon tolerance and broadmindedness—fail to

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realize that the fervor of the early temperance movement came about as a direct reaction to the lawless, hard-drinking aspects of Canadian pioneer life.

Drunkenness was general. The comments of both visitors and early settlers on the subject are almost too numerous to record. Sir Richard Bonnycastle, visiting Upper Canada in 1846, wrote: "Canada is a fine place for drunkards. Think, my dear reader, of whisky at 10 pence per gallon." Later, in 1866, Charles Weld commented on the extent of drunkenness among the lower classes and noted that a quart of whisky could be bought for less cost than a measure of beer in England.

Heavy drinking on Sundays

In 1822 and 1823, John Macdonald, who settled in the New Lanark area in Upper Canada (near Perth), and James Wilson, an Irishman of some education who sought work as a teacher in Upper Canada, mentioned the "godless living of the settlers, who pay no attention to Sunday; regular work and hard drinking was common on Sundays and every kind of liquor was plentiful and cheap. . . . Rum sold for six shillings per gallon, brandy for seven."

An ex-settler, an Irish gentleman, writing of Canada between 1832 and 1834, stated: "Canada is a bad country for very young, unformed minds. . . . It is a place rude and rough and offers not a few temptations to wildness." Certainly, liquor contributed to the brawling for which early Ottawa, or Bytown, was notorious, and to the lawlessness of the Markham Gang and the Tenth Line Blazers.

William Gibbard, born in Lennox County in 1810, remembered when there were more distilleries than grist mills in the country and more taverns than schools. Whisky was considered as indispensable as flour. In many families it was served to each member of the household (including children) in the morning and was regarded as a precaution against the cold and to enable one to do hard work.

And don't think the idea of selling liquor in grocery stores is new. Writing of London, Ontario, whose population was 300 in 1836, Anna Jameson said: "Besides the seven taverns, there is a number of little grocery stores, which are in fact drink houses." Until comparatively recent times liquor and groceries were not only sold together, but advertised together in newspapers and periodicals, along with other things. Thus one shop's advertisement listed: "Fine Cloths, English and Gaelic Bibles, Sugar, Rum and Pipes."

There was little cash among the early settlers. Trade was almost always a matter of barter and this practice made whisky easily available. At any one of the three distilleries in the town of Perth, the farmer could exchange his grain for its value in raw spirits. And many did, for generally there was no cash market for either the sale or export of grain.

"Neither education nor amusements"

Most of the early settlers had come from the eastern frontier areas of North America, northern New York, Pennsylvania and areas adjacent to the Niagara frontier, and for the most part were uneducated and illiterate. In these terms, Anna Jameson tried to explain the coarse, drink-ridden society: "There is, I fear, a good deal of drunkenness and profligacy, for though the people have work and wealth, they have neither education nor amusements." And she defined progress in the Canadian settlements as marked by "first a saw mill or grist mill, then a few shanties or log houses, then a grocery store, then a tavern . . . a chapel . . . and perchance a schoolhouse."

Reverend William Bell, a Presbyterian minister and school teacher, visited many of the settlements where some of the earlier Loyalists and many Americans who had come to Canada in great numbers before the War of 1812 had made their homes. Bell in his day-to-day journal mentions the terrific profanity, common among even the females. "People were more like wild animals . . . the women with long hair hang-

ing over their shoulders and suckling infants." Thus it was that the pioneers, lacking the finer things of life, too often lost all appreciation of their worth.

If these comments appear to represent biased opinion, read the rather jocund remarks of Reginald Fowler, a young British officer who around 1854 spent a year with two friends living in the Bay of Quinte area. He mentioned that these three bachelors, living together, consumed more than 120 gallons of whisky in four months without any of them "approaching insobriety." He attributed this near-immunity "to the bracing climate, which allows whisky to be drunk with impunity." More than likely it was drunk to keep one warm in those drafty log houses.

Were the women drunkards too?

As for social drinking in pioneer times, Fowler noted: "At parties, the whisky goes round as well as the waltz." He implied that even women drank considerably, though his opinion was not generally supported by other writers. Fowler also remarked rather disapprovingly on the scant chaperonage of young Canadian women, who, he reported, went out socially with young British officers in the garrison at Kingston.

Patrick Shirreff, another British visitor, who had considered settling in either Canada or the United States, noted the lack of law enforcement and terrible drunkenness. He could even be wryly humorous about some of the situations he encountered during his visit to Upper Canada. Arriving at an inn, he found not only the landlord tipsy, but three intoxicated patrons draped across various tables and chairs. When his coach arrived, a drunken man was already in it, with his feet out one side, his head out the other. The relief driver at the next stage was drunk, and Shirreff began ruminating on "the possibility of the horses participating in the common vice."

Excessive drinking marked all classes. Shirreff, writing of schools in Upper Canada, remarked: "The masters seldom

remain long, being too fond of whisky." Even as late as 1856, John Shaw, a visiting English educationist, referred to the drunken character of many school teachers. Many of the English gentlemen-farmers who emigrated to Upper Canada took to drink because they could not cope with the hardships and frustrations of pioneer life. "Every halfpay officer that has died in this settlement (Perth)," stated William Bell, "has fallen a victim to drinking."

William Pope, in his journal of 1834-35, noted the heavy drinking by all Upper Canadians and emphasized the need for a temperance society. Amusingly, he commented on the Canadian habit at social gatherings of men keeping to one side of the room, the women to the other. (Some things evidently do not change.) It was "a most decent and elegant custom," in the opinion of one Canadian gentleman whom Pope addressed.

The need for laws to regulate liquor sales was realized very early by men like Richard Cartwright of Kingston, who was instrumental in getting a law passed which forbade pioneer taverns and innkeepers to sell liquor after 10 at night in winter and 9 in the summer, except to travellers and sick persons—a portent, perhaps, of the later liquor-by-prescription practice.

A law for laborers

In 1818, tradesmen and laborers were forbidden to "abide in their homes more than an hour in the daytime in order to drink or tittle," and in 1834 the consumption of liquor was forbidden in shops or buildings of which the shops were part. In 1850 tavernkeepers were made subject to fine and imprisonment in cases in which accidents happened to people to whom they had sold liquor.

Apparently conditions in Lower Canada were not as bad. Frances Hall, an English traveller of 1816-17, compared the two parts of Canada and noted that in Upper Canada, "instead of churches, we have taverns; gaols and assembly rooms

instead of convents, and a half-sulky nod for a French bow."

Ernest J. Lajeunesse, writing about the Windsor border area in one of the Champlain Society publications, stated: "While the immoderate use of drink was typical of frontier society in America, both in Canada and the United States, the evidence of most observers indicates that Canada was apparently one up on the U.S. in at least this one particular." Shirreff made the comparison even less flattering: "Manners and customs of Canadians are essentially Yankee, with less intelligence, civility and sobriety." And this was an Englishman speaking after considerable time spent in both the United States and Canada. Robert Barclay Allardice, a Scottish agriculturist and stock breeder, who visited America in 1841, commented favorably on American hotels, as compared to Canadian ones, and mentioned that the former were often "free from the usual nuisance of a public bar."

The barns rose . . . and fell

If all these comments sound like aspersions on the Canadian way of life in early days, and we point to the friendly bees and other co-operative gatherings as counter-claims, we are told by dependable eye-witnesses that bees only very rarely displayed the hearty, wholesome social atmosphere which is generally depicted. It was a courageous man who would dare to announce a bee at which liquor would not be offered. At most bees, it was available to all from a pail equipped with a dipper, and the pail was frequently replenished by the "grog boss." Often such work as barn raising was so poorly done by highly intoxicated workers that the building had to be re-erected by paid labor. Serious accidents were common.

Elections, cattle fairs, militia musters, social gatherings of all kinds, weddings, dances and funerals—at all these, the celebrating frequently continued as long as a week, and all were occasions for heavy drinking and often vicious brawling in which many a man was badly injured and lives were sometimes lost.

Taverns in most communities had a large upper room which served as a ballroom. At the dances, which went on for days in rural taverns, decent folk went home early after the first evening, for later on, John Mactaggart, who served as an engineer in building the Rideau Canal, tells us, "much obscene conduct is beheld of the lowest and brutal kind."

Crazy wagers were made by intoxicated men. William Bell's journal records that one man who drank half a gallon of whisky on a wager dropped dead. Another, to prove his courage, plunged both hands into a pot of boiling potash. The flesh on both hands was burned away to the bone. Making potash from wood ashes was one of the early settlers' few sources of income. Death from so-called "whisky fever" was common, as was "apoplexy"—in other words, noted Bell, "excessive drinking." One pioneer mother, looking back on those early days, said: "This was a terrible place to raise children. There was a tavern at each corner of this concession."

Moreover, these conditions did not improve as the country grew in population and prospered. John Reid, visiting Toronto in 1834, when the town had a population of just 8,000, stated: "On the whole, it is as dull a hole as I have been in. Appearance of many of the inhabitants would lead me to think that it is a rather dissipated place."

"A sad, drunken place"

John Bigsby, a member of the Boundary Commission in 1823, making a return visit to Toronto in 1845, noted that Ontario's capital city, with the population then of just 24,000, had 91 streets and 107 taverns. Thomas James, visiting in the same year, in *Rambles in the United States and Canada in the Year 1845*, described Toronto as a "sad, drunken place." He also called its people "Torontoites." As for Hamilton, James simply characterized it as a "drunken town" of about 12,000 inhabitants.

Canadian historian James Talman provides statistical evi-

dence of the easy availability of liquor in Upper Canada. In 1851, there were 1,990 inns and taverns in the province; that is, one tavern for 477 inhabitants or one for every 77 families. Distilleries in Upper Canada (then known as Canada West) in 1851 produced 2,159,268 gallons of legally distilled liquor, or almost exactly two and one-half gallons for every man, woman and child.

The liquor was stronger

Between 1871 and 1875, the average per capita consumption dropped to 1.331 gallons and in 1952 it stood at approximately three-quarters of a gallon. Thus, Upper Canadians in 1851 drank more than three times as much as Ontarians in 1952, Talman estimates. And when one considers that pioneer liquor had 50 per cent more alcohol, intoxicant intake for 1851 becomes about five times that for 1952.

In Ontario, as in the Maritimes, the greatest part of the work in arousing public opinion to the dangers of excessive drinking was done by the temperance movement, introduced into Canada in the Eighteen Thirties by the Methodists. It must be kept in mind that the temperance movement was not the Prohibition movement. Its aim was to persuade people to make a personal decision not to use liquor—much as modern campaigners warn against the dangers of cigarette smoking and try to influence people, especially the young, not to develop the habit.

In the beginning, the temperance movement met genuine opposition. The very proposal was scoffed at. In Perth, the master of the district school, who was also publisher of the local newspaper, boasted in his paper that the Perth settlement had never yet been “disgraced” by a temperance society. One non-drinker was refused insurance as being subnormal. Yet Perth, with an original enrolment of just 37 in its temperance society in 1832, by 1836 had six auxiliary branches with more than 600 members .

In Ontario, latest official figures (April 1, 1967-March 31,

1968) released by the Liquor Control Board of Ontario, show that the annual per capita consumption of hard liquor is about one and one-third gallons. If figures for wines, imported and native, are included, consumption reaches close to two gallons per person annually. And if beer is included, it ups the per capita consumption to two and one-third gallons. This is getting fairly close to the pioneers' average, except for today's lower alcohol content.

In view of these most recent figures, it becomes clearly evident that moderation, like toleration, is a relative term, and that the regulation of facilities for liquor sales—as well as the education of the young to the dangers of drinking—remain definite needs in any age.

Le mouvement d'abstinence alcoolique "Temperance Movement" commença ses activités en Ontario au début des années 1830. Ces activités étaient alors menées dans une large mesure sous l'égide de l'Eglise Méthodiste. L'auteur fait remarquer que l'établissement de ce mouvement fut suscité à l'origine dans le but de répondre directement au problèmes posés par l'usage excessif des spiritueux qui sévissait en Ontario au cours de la période pionnière. Il décrit d'ailleurs cet aspect au moyens d'extraits de lettres et de journaux émanant de personnes qui avaient vécu et parcouru l'Ontario à l'époque pionnière.

American Methodists and Alcohol

By William D. Moore

Until last year, neither Jesus Christ nor St. Paul nor John Wesley could have been admitted to the ministry of the United Methodist Church in America: none of them were total abstainers. It was only last year that the General Conference of the church, meeting in Dallas, enacted legislation to the effect that it no longer requires total abstinence of its clergy and laity.

Some church members regret the action of the General Conference; they say that in recent years the church has been soft-pedalling altogether too much on the alcohol issue. After all, the United States Public Health Service has declared that alcoholism is one of the four major health problems in the nation—the others being cancer, mental illness and heart disease. The use of alcohol, then, is a topic on which the church should speak out, and speak strongly.

On the other hand, some members take the view that the use of alcohol ceased to be a matter for public discussion with the repeal of Prohibition; they resent a call to abstinence—and sometimes even a call to moderation—as an invasion of their private lives.

The action of the General Conference represents a withdrawal from the position that a church is entitled to prescribe in detail how its ministers and members should behave, but there is no suggestion that a church can abandon all concern for the personal behavior of its ministers and members. We are firm in the belief that all Christians are called to moral responsibility in every area of their lives, public and private, but we now hold that what constitutes a responsible attitude

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towards the use of alcohol is a matter for the individual conscience to decide. We do not doubt that abstinence can be an entirely good and proper position for a Christian to take, but we no longer seek to force the consciences of all our members in the direction of that position.

If we are concerned—as we must be—with the problems that the abuse of alcohol creates, we cannot ignore the findings of researchers who have been studying these problems. Several studies in the last few years have suggested very strongly that the attitudes towards alcohol that have been associated with the total abstinence position have actually contributed to the high prevalence of alcohol problems. These findings do not necessarily indicate that total abstinence is not a tenable position; but they do suggest that some of the premises on which this position has been based in the past are open to question, and that attempts to impose this position on others may be self-defeating.

One-sided sermons

Many a Methodist “temperance sermon” has been packed with biblical quotations that stress the evils of drinking and seem to support the total abstinence position. These sermons often contain impressive statistics of accidents, crimes, broken homes, diseases and deaths, which they attribute to the use of alcohol. However, these sermons ignore an equal number of biblical quotations that support the use of alcohol in religious ritual and as a beverage of good fellowship; they ignore the concept of alcohol as a gift of God; they do not recognize that the evil effects of alcohol are caused by its misuse, not by the beverage itself. They imply that alcohol is evil in itself, and that any use of alcohol is a sin.

The idea that alcohol is evil in itself is contrary to the biblical doctrine of creation. The Book of Genesis states explicitly that the whole of God’s creation is good (Gen. 1); if this is so, nothing that exists can be evil in itself. Evil, then, is the result of man’s misuse of God’s good gifts. The Jew of

the Old Testament looked on the fruit of his vineyard, both food and wine, as a good gift of God. Wine was to be enjoyed, like any other gift of God: so the Psalmist could write that wine "maketh glad the heart of man" (Ps. 104:15 in A.V., Ps. 103:15 in Douay).

To drink responsibly

The supreme gift of God is freedom of choice: therefore the Jew could choose to drink or to abstain. There is no scriptural authority for the view that abstinence is more acceptable to God than moderate drinking. But if the Jew did choose to drink, he was to drink responsibly. The Old Testament explicitly condemns the abuse of wine: "Who hath woe? who hath sorrow? who hath contentions? who hath babbling? who hath wounds without cause? who hath redness of eyes? They that tarry long at the wine" (Prov. 23:29-30).

The acceptance of all created things—including alcohol—as good gifts of God, and the acceptance of man's responsibility to use these gifts to glorify God, are central to the Judaeo-Christian tradition. Contemporary Judaism strongly maintains these principles, and it may be that the attitudes created by adherence to these principles reflect themselves in the low prevalence of alcoholism among Jews today. Charles Snyder observes, in his study of Jewish drinking patterns: "There are probably more users of alcoholic beverages among the Jewish group than in any other major religio-ethnic group in America; yet rates of alcoholism and other drinking pathologies for Jews are very low."¹ Alcoholism is almost unknown among Jews, although almost every Jewish child is introduced to alcohol at a very early age.

Early Christianity carried on the Old Testament tradition in this regard, despite the narrow view that was apparently taken by some of the Pharisees and their followers. St. Paul held, as he wrote to his disciple Timothy, that "every creature of God is good, and nothing to be refused, if it be received with thanksgiving" (I Tim. 4:4). St. Matthew relates

how Jesus described his own coming and the reaction of some of the people: "The Son of man came eating and drinking, and they say, Behold a man gluttonous, and a wine-bibber" (Matt. 11:19).

As a symbol of fellowship, wine was used at weddings and other social functions, as is shown by the account of the marriage at Cana (John 2:1-11) and the gospel accounts of how Christ drank "the fruit of the vine" with his disciples at the Passover. Wine was also thought to have some medicinal value; thus, St. Paul advises Timothy: "Drink no longer water, but use a little wine for thy stomach's sake and thine often infirmities" (I Tim. 5:23). There was no requirement that the clergy abstain, although St. Paul says that deacons must not be "given to much wine" (I Tim. 3:8).

At the same time, Jesus laid on his followers an ethical demand that gave no quarter to irresponsibility: "But whoso shall offend one of these little ones which believe in me, it were better for him that a millstone were hanged about his neck, and that he were drowned in the depths of the sea" (Matt. 18:6). St. Paul warns the Christians in Corinth that drunkards, among others, shall not inherit the kingdom of God (I Cor. 6:10).

Not to be a stumbling-block

The principle of responsibility is underlined in St. Paul's injunction to the Christians in Rome that no man be a cause of temptation or offence to a brother who might be weaker, or who might take a more narrow view: "There is nothing unclean of itself: but to him that esteemeth anything to be unclean, to him it is unclean. . . . It is good neither to eat flesh, nor to drink wine, nor any thing whereby thy brother stumbleth, or is offended, or is made weak" (Rom. 14:14, 21). That this was not a call to strict abstinence at all times is indicated by the permissiveness shown in other situations.

Not only is there a lack of clear biblical support for total abstinence, but the great majority of the Christian church

has never required it. In some Roman Catholic communities, such as Ireland and Quebec, there are groups that practise and encourage voluntary total abstinence; but the Roman Catholic church has never required total abstinence of either clergy or laity. Not one of the Reformers—neither Luther, nor Calvin, nor Knox—was an abstainer. John and Charles Wesley opposed the use of distilled spirits, but they used wine and beer in moderation.

A far cry from the Bible

It does not follow that all of those who call for total abstinence are busybodies and fanatics who want to impose their standards on others; but most of the temperance sermons that have been preached in the Methodist church are a far cry from the approach of the Bible and the approach of the majority of the Christian church. The result is that most of the Methodists who do drink have no concept of accepting alcohol as a gift of God and of drinking with a sense of responsibility.

If people do not see alcohol as a gift of God to be used responsibly, they tend to see it as evil and to see its consumption as a sin. In this pseudo-moralistic atmosphere, any use of alcohol constitutes abuse, by definition; thus the only way in which alcohol can be used is an abusive way, and the attitudes that label alcohol as evil result in its being consumed in guilt. As Clinebell observes, "there is evidence that a one-track abstinence policy may increase problem drinking, both by surrounding drinking with emotional conflict, and by failing to provide ethical guidelines."²

Slang shows recklessness

This abusive, guilt-ridden style of alcohol use is reflected in much of our drinking slang: we speak of having a beer-bash or a beer-blast, or painting the town red; we take a shot, a slug, or a smash; we get stoned, smashed, or hammered. These are violent words; they illustrate the reckless mood of

much of our drinking: the irresponsible use of a gift of God.

J. H. Skolnick studied a random sample of male college students who used alcohol, including Jews, Episcopalians, Methodists, and students who had no religious affiliation themselves but whose parents belonged to a denomination that preached an abstinence doctrine. He recorded the social complications that resulted from the drinking of these students, such as failed obligations, damaged friendships, and accidents or injuries. Among the various denominational groups, the proportions of subjects who had had social complications resulting from their drinking were as follows: Jews, 4 per cent; Episcopalians, 39 per cent; Methodists, 50 per cent; and those with no religious affiliation but with an abstinence background, 57 per cent.³

Skolnick also found that 1 per cent of the Jews, 9 per cent of the Episcopalians and 22 per cent of the Methodists had their first drinks in automobiles. Among the Methodists, 67 per cent said that their fathers had no knowledge of their drinking; the comparable figure for the Episcopalians was 37 per cent and for the Jews 10 per cent.⁴

The culture-conflict theory

"Total abstinence teaching," Skolnick observes, "seems to be a double-edged weapon. On one side, it expounds and implants a repugnance to drinking as well as to intemperance; on the other, by identifying the act of drinking with intemperance, it suggests that the way to drink is, likewise, intemperately. It thus, in some people, inadvertently encourages the behavior it most deplors."⁵ His findings support the culture-conflict theory of why drinking Methodists have a high rate of drinking problems: "The conflict appears akin to that experienced by immigrant groups. What is forbidden by the in-group (the religious organization) may be supported even demanded, by the larger culture."⁶

In Mulford's 1963 study of American drinking behavior, 8 per cent of Methodists who drank reported problems asso-

ciated with drinking. The only large denomination that has a *majority* of abstainers—the Baptists, with 52 per cent—reported a rate of problem drinking twice as high as that of the Methodists.⁷

John Keller made an interesting observation about religious denominations and alcoholism rates in a lecture at the Rutgers Summer School of Alcohol Studies in 1966. The population of Wisconsin, he noted, is about one-third Roman Catholic, one-third Lutheran, and one-third other Protestant denominations. The Catholic and Lutheran churches leave it to the individual to decide whether to drink or not, although they insist on moderation and responsibility. On the other hand, the churches that about 90 per cent of the “other Protestants” belong to hold very strong total abstinence positions.

Just as high a rate

Nevertheless, Keller observed that admissions for alcohol problems to a state hospital in Wisconsin ran about one-third Catholic, one-third Lutheran, and one-third “other Protestant.” In other words, the “other Protestant” groups had just as high a rate of alcoholism as the Catholics and Lutherans, despite their total abstinence doctrines. Keller concluded that although a slightly smaller proportion of members of the “other Protestant” groups drank, the chances of their developing alcohol problems were much greater.

A serious theological question is involved when any person, group, or organization tries to force, coerce or use undue persuasion in another person's decision-making. This is a denial of the other person's freedom and a denial of the integrity of his personality. The love of God never violates the freedom of the person, for response is genuine only when choice is made freely. The individual who abstains from liquor, for instance, without having freely chosen to do so has not acted morally; he has merely obeyed an injunction under fear of condemnation. John Keller defines a moralist

as "a man who can't let another man go to hell even if the other man really wants to go." By contrast, Keller says, "The amazing thing about God's love is that it is a love that will let you go."⁸

The studies of Skolnick and Mulford suggest that the religious bodies that view alcohol as a gift of God have much to teach us. When a person who comes from a group that takes a condemnatory attitude towards alcohol takes his first drink, his guilt is multiplied and he feels severed from the group.⁹ This severance magnifies his sense of loneliness, guilt and anxiety. Attempts to resolve these feelings tend to perpetuate his drinking. Not only are there no ethical guidelines for drinking, but if a person develops a drinking problem he will not seek help from the group because of his fear of condemnation.

This is not to infer that members of the more tolerant groups have no drinking problems; but when a member of such a group does encounter a problem he is not ostracized from the group at the very time when he needs understanding and help. In the more tolerant groups, a problem drinker seeks help much more readily. This is illustrated by a study of Clinebell's, which shows that ministers who leave alcohol decisions to the individual see four times as many alcoholics a year for counselling as do ministers who advocate prohibition and total abstinence.¹⁰

The failure of negativism

It seems, then, that there are two things wrong with the negativistic attitude that has been associated with total abstinence in the past; it is unscriptural, and it has not worked; in fact, it has contributed to the perpetuation of the very problems it has sought to eliminate. The teetotalling, prohibitionist congregations have failed to recognize alcohol as a gift of God, have failed to give ethical guidelines for its use, have failed to explore the problems that underlie the abuse of alcohol, and have failed to offer understanding and help to

people with alcohol problems; they have simply said "Don't drink," and condemned alcohol, liquor stores, and the liquor industry as works of the Devil.

The times call for positive attitudes and positive actions. The recent enactment of the General Conference reflects the adoption of a more constructive attitude towards alcohol in the United Methodist Church of America, supplanting the moralistic and condemnatory attitude that has too often prevailed in the past. Contemporary research reinforces what the scriptures, rightly understood, have always taught: that alcohol is one of God's many good gifts to man, that we must allow the individual to exercise his freedom of choice in matters of behavior, and that we must encourage him to exercise his freedom with an equal measure of responsibility. This approach is likely to do more good than preachments against the Demon Rum have done; it will almost certainly do less harm.

References

- ¹Snyder, Charles R. "Culture and Jewish Sobriety: The Ingroup-Outgroup Factor." In Pittman, D. J., and Snyder, C. A., (eds.), *Society, Culture and Drinking Patterns*. New York: John Wiley and Sons, 1962.
- ²Clinebell, Howard J., Jr. "Pastoral Care and Abstinence." *Christian Advocate*, February, 1968.
- ³Skolnick, Jerome H. "Religious Affiliation and Drinking Behavior." *Quarterly Journal of Studies on Alcohol*, Vol. 19, No. 3, September, 1958.
- ⁴*Ibid.*
- ⁵*Ibid.*
- ⁶Skolnick, Jerome H. "The Stumbling Block. A Sociological Study of the Relationship Between Selected Religious Norms and Drinking Behavior." Doctoral Dissertation, Yale University, 1957 (Abstract No. 7999).
- ⁷Mulford, Harold A. "Drinking and Deviant Drinking, U.S.A., 1963." *Quarterly Journal of Studies on Alcohol*, December, 1964.
- ⁸Keller, John E. *Ministering to Alcoholics*. Minneapolis: Augsburg Press, 1966.

⁹Plaut, Thomas F. A. *Alcohol Problems: A Report to the Nation by the Cooperative Commission on the Study of Alcoholism*. New York: Oxford, 1967.

¹⁰Clinebell, Howard J., Jr. *Understanding and Counseling the Alcoholic*. Nashville: Abingdon, 1956.

L'auteur est un pasteur de l'Eglise Méthodiste du sud des Etats-Unis. Il nous affirme que ce n'est que l'année dernière que son église révoqua son exigence traditionnelle selon laquelle ses ministres devaient s'abstenir totalement de spiritueux. Cette décision, dit-il, représente un revirement d'attitude de la part de l'Eglise Méthodiste en ce qui concerne les boissons alcooliques; bien que l'abstinence demeure toujours une saine et heureuse disposition chez un bon chrétien, l'église ne cherche plus à exercer une pression de conscience à cet égard vis-à-vis de ses membres. L'auteur fait remarquer en outre que les recherches entreprises au cours des années récentes ont prouvé d'une façon tout à fait évidente que la doctrine d'abstinence complète préconisée par certaines confessions religieuses n'a effectivement contribué qu'à accroître parmi les membres les problèmes dûs à l'alcool.

Au verso:

Les auteurs passent en revue les faits se rapportant aux accidents de la route dûs aux alcooliques. De nombreuses études sur cette question ont établi que les alcooliques présentent proportionnellement de bien plus grands risques d'accidents de la route que les non-alcooliques. Les chercheurs n'ont cependant pas considéré assez sérieusement les facteurs responsables qui sont à la base de tels accidents. Les deux éléments essentiels semblent être liés à l'altération physiologique due à l'usage excessif de l'alcool d'une part et à des caractéristiques personnelles d'autre part, telles que l'impulsivité, l'hostilité et la tendance au suicide. Les auteurs exposent les conditions dans lesquelles ces facteurs pourraient susciter des réactions réciproques entre eux.

Traffic Accidents of Alcoholics

By Reginald G. Smart and Wolfgang Schmidt

Studies in such widely separated areas of North America as Ontario,¹ Michigan² and California^{3, 4} have shown that alcoholics have traffic accident rates about twice as high as do non-alcoholics. In California, Waller⁴ has estimated that alcoholics may be involved in 41 to 62 per cent of the known drinking-related accidents. Most alcoholics' accidents follow heavy drinking. To date, little attention has been focused on the possible mechanisms of these drinking accidents.

Two main sets of factors, one physiological and one psychological, could be involved. For example, Selzer⁵ has construed "personality versus intoxication" as the critical factor in alcoholics' accidents. Alcoholics' drinking-related accidents could result primarily from the impairment by alcohol of sensorimotor functions, or because alcohol reveals or creates personality traits such as hostility, impulsiveness or self-destructiveness. The purpose of this paper is to review the evidence for the physiological and psychological points of view. The result is an argument for an interaction between the two factors with perhaps the psychological being most important among alcoholics and less important among non-alcoholics.

There can be little doubt that sensorimotor impairment should be an important contributor to alcoholics' accidents. Several studies have shown that most alcoholics' accidents occur after heavy drinking. Schmidt and Smart¹ in 98 clinically diagnosed alcoholics found that almost all of their accidents occurred after drinking. Selzer *et al.*² reported the same findings in a group of alcoholics in Michigan.

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Smart and Schmidt⁶ have recently identified the alcoholic drivers in an early road survey of accident-involved drivers (Toronto, 1951) in which some of them submitted to breath tests for alcohol. Among the 96 drinking drivers, 22 were alcoholics or problem drinkers (i.e., they had had clinical treatment for alcoholism or several convictions for public intoxication), but among the 238 drivers who had not been drinking at the time of the accident only 19 were alcoholics or problem drinkers. It was also found that at the time of their accidents the excessive drinkers had an average blood alcohol level of 0.13 per cent while that of the non-alcoholics averaged only 0.07 per cent. The alcoholics were also more often responsible for their accidents in terms of driving errors.

Driving skills reduced

The average blood alcohol level attained by the alcoholics suggests a high degree of impairment. A number of driver-trainer and road tests have shown that sensorimotor coordination in most persons is disrupted at very low blood alcohol levels. For example, Bjerver and Goldberg⁷ found 25 to 30 per cent impairment in driving ability at blood alcohol levels of only 0.05 to 0.06 per cent. A later study⁸ also using driving tests showed impairment at only 0.05 per cent, although heavy drinkers were less impaired than light and moderate drinkers. Nevertheless, all drivers showed reduced driving skills at a level of 0.15 per cent regardless of their drinking experience. Similar findings have been reported in studies with driving tests and with driver-trainers.*

Of course, many of these tests are rather artificial compared to the usual driving situation; the subject lacks the immediacy of driving—there are no other cars, or pedestrians, passengers, traffic lights or distractions. Also, such tests measure impairment with no indications about the degree of impairment

* See Carpenter⁹ for a review.

actually necessary to result in accidents in real driving situations.

Another difficulty is that none of these studies have used alcoholics; the subjects were presumably social drinkers and hence we are not sure how much the average alcoholic's driving skill is impaired at a given blood level. Goldberg's early studies¹⁰ showed that heavy drinkers have less sensorimotor impairment than do moderate drinkers and abstainers at every blood alcohol level. Also, Penner and Coldwell¹¹ showed that moderate drinkers were more often termed impaired by examining physicians than were heavy drinkers.

Alcoholics less impaired

In more recent studies, Mendelson and his colleagues¹² found that daily amounts of whisky up to 30 oz. of 43-percent alcohol produced little effect on the motor skills of alcoholics even after several weeks. These alcoholics also showed only mild degrees of intoxication, without ataxia, gross motor disturbances or difficulty in walking. Social drinkers under this regimen would quickly show the gross signs of intoxication and would probably be almost stuporous within a few days. Early studies by Hollingworth¹³ and Goldberg¹⁰ have both shown striking motor impairment in social drinkers after much smaller amounts of alcohol.

Unfortunately, neither Goldberg nor Mendelson employed tasks as complicated as driving. However, the absence of gross motor impairment after the consumption of large amounts of alcohol in these studies suggests that impairment may have been over-emphasized as the prime factor in alcoholics' accidents. In any case, it is clear from Goldberg's study and suggested by Mendelson's that alcoholics are far less impaired by alcohol than are social drinkers or abstainers.

Further evidence directly relevant to driving problems has been found by Brenner¹⁴ who worked with data from the Grand Rapids survey of alcohol levels in drivers involved and not involved in accidents.¹⁵ In his study, those who drank

once a year or less frequently were twice as likely to have an accident at blood alcohol levels of 0.05 per cent or more than those who drank weekly or more frequently. This was despite the finding that more of the frequent drinkers had high levels (above 0.15 per cent) than did infrequent drinkers.

Possibly, frequent drinkers and alcoholics, compared to infrequent drinkers, gain considerable experience in drinking and driving which allows them to drive with far less impairment of the type likely to result in accidents. In a similar vein, Waller⁴ has shown that alcoholics in accidents are responsible for 88 per cent of their accidents but they were known to have been drinking in only 60 per cent of them. He has suggested that the difficulty of recognizing drinking in the impaired but non-intoxicated alcoholic may explain this difficulty.

The alternative explanation for the alcoholics' accidents is that their personality characteristics, alone or in combination with alcohol, make accidents more likely. One of the strongest proponents of this theory, Selzer,⁵ has argued that "the alcoholic's drinking often releases behavior motivated by underlying personality traits . . . variously described as chronic hostility, depression, self-destructiveness, and feeling of invulnerability and omnipotence." A psychiatric study by Selzer *et al.*² found some evidence for this theory. Fifty alcoholic and 50 non-alcoholic male drivers were rated by psychiatrists on a variety of psychopathological variables. Factors of paranoid thinking, depression, suicidal preoccupation and chronic rage and resentment showed the highest correlations with accident rates among the alcoholics.

The suicide factor

The question of suicidal preoccupation in alcoholics generally and drivers in particular has been pursued along several lines. For example, Selzer and Payne¹⁶ showed that alcoholics who had seriously considered suicide or had made one or more suicide attempts had twice as many traffic accidents as those who were not suicidal.

Additional studies* have shown that the automobile is sometimes chosen as an aid to suicide and that some "accidents" are in fact poorly concealed suicides.¹⁸ Several independent studies have shown that alcoholics have both high suicide rates and high death rates^{19, 20} in all types of accidents including driving accidents. Brenner¹⁴ has shown that alcoholics are about 4½ times as likely to die in a traffic accident as are persons in the general population. A large amount of evidence and inference, then, supports the proposition that personality is involved in alcohol-related accidents in alcoholics.

Problems with psychological theories

Unfortunately, these psychological theories are not without difficulties. It is uncertain how alcohol affects aggressive, hostile and self-destructive impulses in alcoholics, and whether their accidents are more related to enduring personality traits or to some temporary alcohol-induced behavior. Both of these possibilities provide competition for the sensorimotor-impairment theory. Another difficulty is that many accidents with alcoholics are of the single-vehicle type¹ in which the driver hits some fixed object at the side of the road. Many of these appear to give little release for hostile or self-destructive impulses because they are minor in nature; many appear to result from lapses of attention or falling asleep.

Another major problem in this whole area concerns the difficulty of obtaining pure measures of "impairment" and "personality." Both always occur in the same driver and some interaction between the two will always exist. There is no way in which we can give alcohol so that it impairs sensorimotor skills but leaves personality characteristics untouched. What is needed, of course, is a broad survey of accident-involved drivers in which levels of impairment in alcoholics and non-

* See Haight¹⁷ for a review.

alcoholics can be related to personality characteristics and to accident probabilities.

Within the bounds of an interactive theory, however, it may be possible to assign greater or lesser importance to one of the factors, at least for certain driver populations. Some data relevant to this question have been collected by Waller²¹ in a study of alcohol-related fatalities in California. He found that persons with low blood alcohol levels (150 mg. per 100 ml. or less) in such accidents were mainly drivers under 25 years and pedestrians over 65. Here one could surmise that the youthful, as the least experienced drinkers and least experienced drivers, succumb to the impairing effects of relatively low blood alcohol levels. Personality factors should be less important than sensorimotor impairment as causes of their alcohol-related accidents.

Alcoholics, however, are older and more experienced drivers. Several studies^{8, 10, 11} show that they have acquired "tolerance" to alcohol. In their accidents, at the same blood levels as the younger non-alcoholic driver, personality factors should be of relatively greater importance. The alcoholic, however, frequently drinks beyond the point at which his tolerance for alcohol could overcome its impairing effects in driving. For example, Waller²¹ found that 60 per cent of the fatally injured drivers (aged 25 to 64), most of whom were alcoholics, had blood alcohol levels over 200 mg. per 100 ml. At these levels even alcoholics would be impaired; thus Mendelson¹² found that gross signs of intoxication began to appear in his alcoholics at levels above 200 mg. per 100 ml.

Teen-agers' accidents

Hyman's analyses²² of the Grand Rapids data are also relevant to the question of impairment and age. He found that "few teen-age accidents occur after drinking," but that low blood alcohol levels (0.01 to 0.04 per cent), which are not associated with high accident vulnerability in those aged 25 to 69, were associated with markedly high vulnerability in

those less than 18. The vulnerability scores of those aged between 18 and 24 were intermediate between the other two age classes. This would seem to indicate that impairment may be more important among the youngest drivers.

Far more investigations of the relative importance of impairment and personality in the accidents of alcoholics are needed. Only studies allowing concomitant variation of factors such as drinking history, age and personality, could definitively answer the question of the relative importance where a complex interaction is so obviously involved.

References

- * ¹Schmidt, W. S., and Smart, R. G. "Alcoholics, drinking and traffic accidents." *Quart. J. Stud. Alc.* 20: 631-644, 1959.
- ²Selzer, M. L., Payne, C. E., Quinn, J., and Westervelt, F. H. "A depression-aggression syndrome related to accidents caused by alcoholic drivers." *Proc. 4th int. Conf. Alc. Traffic Safety*, pp. 297-303, 1966.
- ³Waller, J. A., "Chronic medical conditions and traffic safety; review of the California experience." *New Engl. J. Med.* 273: 1413-1420, 1965.
- ⁴Waller, J. A. "Patterns of traffic accidents and violations related to drinking and to some medical conditions." *Quart. J. Stud. Alc.*, Suppl. No. 4, pp. 118-137, 1968.
- * ⁵Selzer, M. L. "Personality versus intoxication as critical factor in accidents caused by alcoholic drivers." *J. nerv. ment. Dis.* 132: 298-303, 1961.
- * ⁶Smart, R. G., and Schmidt, W. "Responsibility, blood alcohol levels and alcoholism." Paper presented at Symposium on the Prevention of Highway Injury, Ann Arbor, Mich., 1967.
- ⁷Bjerver, K., and Goldberg, L. "Effect of alcohol ingestion on driving ability; results of practical road tests and laboratory experiments." *Quart. J. Stud. Alc.* 11: 1-30, 1950.
- ⁸Coldwell, B. B., Penner, D. W., Smith, H. W., Lucas, G. H. W., Rodgers, R. F., and Darroch, F. "Effect of ingestion of distilled spirits on automobile driving skill." *Quart. J. Stud. Alc.* 19: 590-616, 1958.
- * ⁹Carpenter, J. A. "Effects of alcohol on psychological processes." In Fox, B. H., and Fox, J. H., eds. *Alcohol and traffic safety*. Beth

esda, Md.: U.S. Department of Health, Education, and Welfare, 1963.

¹⁰Goldberg, L. "Quantitative studies on alcohol tolerance in man; the influence of ethyl alcohol on sensory, motor and psychological functions referred to blood alcohol in normal and habituated individuals." *Acta physiol. scand.* 5 (Suppl. 16): 7-128, 1943.

¹¹Penner, D. W., and Coldwell, B. B. "Car driving and alcohol consumption; medical observations on an experiment." *Canad. med. Ass. J.* 79: 793-800, 1958.

¹²Mendelson, J. H., ed. "Experimentally induced chronic intoxication and withdrawal in alcoholics." *Quart. J. Stud. Alc.*, Suppl. No. 2, 1964.

¹³Hollingworth, H. L. "The influence of alcohol." *J. abnorm. soc. Psychol.* 18: 204-237, 311-333, 1923.

¹⁴Brenner, B. "The rate of motor vehicle accident involvement associated with patterns of alcohol use." *Proc. 4th int. Conf. Alc. Traffic Safety*, pp. 57-61, 1966.

¹⁵Borkenstein, R. F., Crowther, R. F., Shumate, R. P., Ziel, W. B., and Zylman, R. "The role of the drinking driver in traffic accidents." Bloomington: Indiana University, Department of Police Administration, 1964.

¹⁶Selzer, M. L., and Payne, C. E. "Automobile accidents, suicide and unconscious motivation." *Amer. J. Psychiat.* 119: 237-240, 1962.

¹⁷Haight, F. "Some comparisons between traffic death and suicide." *Automob. e automob. Industr.* 5: 1-52, 1965.

¹⁸MacDonald, J. M. "Suicide and homicide by automobile." *Amer. J. Psychiat.* 121: 366-370, 1964.

¹⁹Tashiro, M., and Lipscomb, W. R. "Mortality experience of alcoholics." *Quart. J. Stud. Alc.* 24: 203-212, 1963.

²⁰Brenner, B. "Alcoholism and fatal accidents." *Quart. J. Stud. Alc.* 28: 517-528, 1967.

²¹Waller, J. A. "Drinking drivers and driving drinkers—the need for multiple approaches to accidents involving alcohol." Paper presented at Symposium on the Prevention of Highway Injury, Ann Arbor, Mich., 1967.

²²Hyman, M. M. "Accident vulnerability and blood alcohol concentrations of drivers by demographic characteristics." *Quart. J. Stud. Alc.*, Suppl. No. 4, pp. 34-57, 1968.

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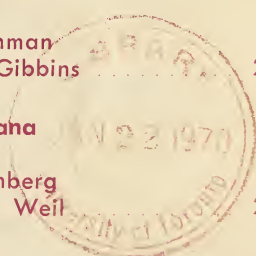
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Alcoholics Anonymous — One Man's View

By Charles Aharan

One New Year's day in the early 1950's, I was contacted by an old navy friend who had celebrated too well the night before and for several nights before that. He asked me to help him.

At that time I was attending the University of Western Ontario. I arranged to meet him in the YMCA in London. I went there with no idea of what I was going to be faced with or what I was going to do. There was my friend who had been drunk, I would think, for about three or four weeks. He was dishevelled and dirty and very sick. I had no idea what to do, but I noticed on the bulletin board at the "Y" that there was an AA meeting going on at that time in a certain room; so I took my friend up and we were welcomed.

This was the beginning of a lengthy and interesting associa-

Dr. Aharan is Director of the Lake Erie Region of the Addiction Research Foundation. This article is reprinted from an A.R.F. pamphlet, now out of print, on Alcoholics Anonymous. It was originally based on a talk Dr. Aharan gave to the A.R.F.'s annual summer school in Ottawa in 1965.

tion with AA. At that time I was searching around for an M.A. thesis topic. I became interested in AA immediately, and I did my research in this field. AA members became subjects of my work. As a result of this I attended AA meetings regularly—at least once a week—for about six years.

An AA member, in the tradition of the program, is not allowed to become an authority on AA. He cannot stand up and tell you what AA is. He can only tell you what AA means to him. So—not being a member—I can perhaps describe and talk about AA with greater freedom than an AA member could.

“Keep an open mind”

It is customary in an AA meeting for the speaker, at some point, to ask for an open mind. He says that what he is talking about is just his story, just his interpretation, and may not be acceptable to all the members of his audience. He asks them to let it go in one ear and out the other if they do not like it and, if there is anything they do like, to hang onto it. I am going to ask you to do the same thing.

In many respects, the history of AA is the history of one man, Bill W. In 1934, Bill was a fairly successful American businessman, a stockbroker on Wall Street. It was his experience and his method of recovery that led directly to the founding of AA.

I cannot resist quoting something that Bill wrote about his initial experiences with alcohol. During the First World War, as a young artillery officer, newly commissioned and newly married, Bill found himself caught up in the social life of a Stateside garrison town in wartime. This is how he describes it: “There we [Bill and his wife] were projected among the society folk of the town. For the first time in my life I saw a butler. Again came that terrible feeling of inadequacy, that shy inability to speak more than two or three words in a row. It was overwhelming. But one night someone handed me a Bronx cocktail. . . . Ah, what magic! I had found the elixir of life! Down went that strange barrier that had always stood

between me and people around me. My new companions drew near to me and I drew near to them. I was part of life at last. I could talk easily, I could communicate. Here was the missing link!"*

Bill found alcohol so rewarding that he continued to use it frequently and heavily. By the time of his discharge from the army at the end of the war he was a very heavy drinker. He started working for a railroad, was discharged, and then went into Wall Street. He was quite successful, and was recognized as an up-and-coming young man on the Street. However, his drinking was very, very heavy. By 1934 it had completely dominated his life. During a period of hospitalization that year he was declared hopeless by a friend of his and by his doctor, Dr. William D. Silkworth, who figures prominently in the early history of AA.

Ebby impresses Bill

It was when he was recovering from his last and most grievous bender that Bill was visited by a friend of his who had achieved sobriety through affiliation with the Oxford Group. This friend, Ebby, was known to Bill as at least as bad a drunk as he was. Bill was impressed when Ebby came to visit him. Bill was extremely resistant and hostile to the God notion or the God concept; nevertheless he was impressed. Here was a man who had been at least as bad as if not worse than he, who was sober. This was the start—the way he began to get the idea of the therapeutic value of one drunk talking to another.

Bill rebelled against "the God bit" and characteristically decided that the only way to really come to grips with this issue was to taper off the bender he was on when Ebby called. His tapering-off attempts turned out the same way they had always done, and he was hospitalized again. He writes that he never forgot this experience of the visit from his friend. When

* *Alcoholics Anonymous Comes of Age* (New York: Alcoholics Anonymous Publishing, Inc., 1957), p. 54.

he was in hospital, he began to consider the spiritual issue more seriously; he writes that he called out to God asking for Him to declare Himself. He says his words were: "If there is a God, let Him show Himself! I am ready to do anything—anything!" Bill describes what happened after that as a blinding flash of light, an exposure to the spiritual wind, and so on—the ways in which people try to explain a sudden and dramatic spiritual experience.

A psychotic episode?

This was an extremely powerful event in his life. After it had subsided a little he began to question it. He began to use his education and sophistication. He began to wonder if he had been hallucinating and if this was some kind of psychotic episode. He was reassured by his doctor that it was genuine and that these things can often happen in a person's life. His doctor gave him a copy of William James's *Varieties of Religious Experience*, which he studied carefully. In this he read that nearly all religious experiences have a common denominator: a complete hopelessness and a deflation at depth were almost always required to make the recipient ready. The phrase that Bill picked up and emphasized is "deflation at depth," which I am sure is related to what I will mention later—the necessity of "hitting bottom" in order for recovery to take place.

As a result of this experience, Bill felt immediately freed and emancipated. Somehow, he recognized what was tremendously important—that he had to communicate this experience to other alcoholics. He became an evangelist. He went about trying very hard to cure all the alcoholics in New York City, and he was perfectly confident that he was going to be able to do this. However, he had no success at all in that period. At this time he was associated with the Oxford Group.

He became re-established in business, and was becoming moderately successful. In May of 1935 he was sent by a group that he represented to Akron, Ohio, to close an important

business deal. When he got to Akron the deal fell through—he failed. I am telling you this because it is important in terms of the legend, the myth, or, if you like, the kind of atmosphere that exists within AA meetings about his founding AA.

He describes what happened to him after the failure of his business mission. He was tremendously upset and depressed. He found himself in the hotel lobby, and he paced back and forth. His route took him from the church directory at one end of the lobby to the entrance of the bar at the other. He walked back and forth, and he didn't know what he was going to do. He panicked. Finally he turned to the church directory and picked out a name. He happened to pick the name of an Episcopalian clergyman. He phoned this man and said, "I am a recovered alcoholic and I desperately need to know somebody to talk to, another alcoholic. Could you help me?"

This was rather a strange and unusual kind of request for a clergyman to be receiving in those days. It wouldn't, perhaps, be so unusual today. However, this clergyman did give him the names of ten people who might be able to help. He phoned them all, and got no answer from the first nine. The tenth one he got in touch with was a Mrs. Seiberling, and she thought she might be able to help. She invited him to go over to her house.

Bill meets Dr. Bob

When he got there he explained further what he was trying to do and she put him in touch with a certain Dr. Bob S., who became the co-founder of AA. Dr. Bob was a well-known doctor in Akron, and a very heavy drinker—an alcoholic. They got together, and Bill told him of his experiences. This seemed to have a very meaningful effect on Dr. Bob. Bill's business stay in Akron was extended somewhat, and he stayed with Dr. Bob. He nursed Dr. Bob through his one slip, and it was through this association that the idea of AA began to grow.

Bill W. is the first to acknowledge the importance of non-AA members to the development and creation of AA. He

would say that if it were not for the non-alcoholic friends of AA, the organization would not have survived its initial difficult years. In 1937 Bill separated himself from the Oxford Group. This was because of what he saw as the authoritarianism of the movement. The Oxford Group at that time, and I guess since, requires members to make public testimonials. This was an extremely difficult thing for the early alcoholics to think about, and so the concept of anonymity crept in through necessity. The authoritarian presentation of God and God's power was also repugnant to many alcoholics. So Bill W. and Dr. Bob separated themselves from the Oxford Group.

Four hundred thousand members

In 1937 they were able to count 40 recoveries, and in 1938 The Alcoholic Foundation* was established to serve as a trusteeship for AA. In December of 1938 the Twelve Steps were written, and by 1939 the membership had reached 100. In 1939 the Big Book was published. Perhaps as important as its publication was the review given it by Dr. Harry Emerson Fosdick. In 1939 *Liberty* magazine published an article on AA that had considerable effect. The title of the article was "Alcoholics and God." In 1941 a feature article about AA appeared in the *Saturday Evening Post*. This provided tremendous impetus to the growth of the organization. By 1957 AA claimed 200,000 members in 70 countries around the world. It claims more members now—over 400,000 as of January, 1969. This is an estimate of course, because it is extremely difficult to be sure how many members there are.

Now, what is AA? The foregoing was a brief history of the experience of the founders, but what is it that evolved through their experiences? I thought perhaps I should quote the "AA Preamble," which is often read at AA meetings: "Alcoholics

* The Alcoholic Foundation is now known as the General Service Board of Alcoholics Anonymous. It serves as the custodian of AA traditions and over-all service. The Board is made up of alcoholics and non-alcoholics.

Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.”

The Twelve Steps are the basis of the therapeutic program in AA. I just want to mention briefly some aspects of the Steps, and some of the meanings that may grow out of them.

The First Step is: “We admitted we were powerless over alcohol . . . that our lives had become unmanageable.” This is a tremendously difficult step, and most of the members say that this is the hardest one to take. Sometimes, they say, it takes 30 years and endless thousands of dollars and all kinds of misery and degradation. The interesting thing about this step is that it requires individuals to begin a process of submission and surrender by admitting that they are powerless over alcohol and that their lives have become unmanageable.

“Hitting bottom”

This kind of admission, this kind of surrender, I think, helps the individual to become amenable to new ideas and to recognize and accept the need to change the way he is living. Dr. Harry M. Tiebout, in an article called “The Therapeutic Mechanism of AA,”* emphasizes the act of surrender as the therapeutic value in AA—he emphasizes the surrender of a narcissistic ego. It is the inflated ego of the alcoholic that has to collapse. We describe this as the destruction of the rationalization system, or, more commonly and effectively, “hitting

* In *Alcoholics Anonymous Comes of Age*, pp. 309-319.

bottom.” The individual has to arrive at the stage where his props go out from under him. He has to acknowledge that he is incapable of managing his existence.

The Second Step, “Came to believe that a power greater than ourselves could return us to sanity,” again suggests further surrender, further submission, and the beginning of an idea of commitment—“came to believe.” Came to believe that there is, first of all, something more important than me. To believe that I am not necessarily the centre of the universe—there is something outside of me. To believe that this something—if I commit myself to it—may be able to restore me to sanity.

Return to sanity

An interesting thing in AA is that there is a tremendous resentment among some members of any suggestion of psychological or emotional incompetence. Yet one of the important phrases in the Second Step is “return us to sanity.” Again, this step—when a person accepts it and interprets it in the light of his own experience—cannot be made without a surrender of the ego and a willingness to admit that he is incapable of conducting his affairs.

The Third Step emphasizes to a much greater extent the notion of commitment: “Made a decision to turn our will and our lives over to the care of God *as we understood Him.*” I think the emphasis here is the beginning of commitment—turning one’s will and one’s life over to the care of God, as He is understood. This is what is tremendously important here: the nature of the deity, if you like, is never explained. It is the individual’s own personal deity and he can make out of it what he wants. In actual fact, most people seem to return to the deity of their childhood.

It often seems to me that the kind of deity that is talked about in AA is talked about in a rather profane, idolatrous way—referred to as the “Man Upstairs,” or the “Senior Partner,” or the “Boss,” and these kinds of things. However, the thing that is important is that this enables people to accept

it. Particularly these resistant and rebellious people are encouraged to commit themselves to the notion of God that stems out of their own understanding. Whether it actually does stem out of their own understanding or not, the fact is they are not told what it is that they must commit themselves to. They are allowed to put their own stamp on it. In my opinion, success in the program depends very heavily on whether they do just that.

The Fourth Step is: "Made a searching and fearless moral inventory of ourselves." Here again the emphasis is on the need to examine myself in depth. What kind of person am I? This is possible only after the system of rationalization and defenses begins to crack. A person needs to see himself as he is.

The Fifth Step is: "Admitted to God, to ourselves and to another human being the exact nature of our wrongs." This takes into account the well-recognized and long-known value of a public utterance about oneself. It is one thing to say secretly to oneself, "I am a liar;" this is a very easy thing to do; but to hear one's voice saying it out loud and sincerely to another human being puts it on record—attaches a reality to it that it may not have when it is only whispered in the secrecy of one's room. It is the sort of thing, I believe, that is reflected in many people when they have a severe pain in their belly but they won't go to the doctor for fear the doctor is going to tell them, "You've got cancer." Somehow, as long as no one says it, I haven't got it.

A shared commitment

It seems to me that there is a necessity for a commitment to another person; it has a great deal of therapeutic value. AA emphasizes that the Fifth Step should be taken *with* someone; it is not necessarily a public testimonial; it is a commitment to one other human being and to God about the exact nature of one's own shortcomings.

The Sixth Step: "Were entirely ready to have God remove all these defects of character." This again helps the individual

to recognize—and tends to support the idea—that he cannot solve his problems without help. It begins to enable him to transfer his dependences, and to generate at least a healthier kind of dependent relationship. This has been a big factor in his illness and in his life up to this point.

The Seventh Step: “Humbly asked Him to remove our short-comings.” The Eighth Step: “Made a list of all persons we had harmed and became willing to make amends to them all.” The Ninth Step: “Made direct amends to such people wherever possible, except where to do so would injure them or others.”

The importance of action

The Seventh, Eighth and Ninth Steps are the action part of the program, and a very important part. First of all, the alcoholic has to manage his resentments, and he has to be able to translate some of his new feelings into activity. He is burdened with a great sense of guilt because of all the awful things he has done. He tends to attribute this feeling that he has about his own personal unworthiness to his drunken behavior. I, personally, don't think that it started there. But he certainly attributes it to his drunken behavior.

It is extremely valuable and useful for him to be involved in activity which he feels will—in some way—undo the guilty acts that he remembers. I can't overemphasize the value of this. I've seen it happen so many times in my own psychotherapy with patients, once they are able to take the initiative and go and do something they believe in their hearts they should do. When they have done it, a sense of well-being comes about within themselves; they feel good about themselves.

The Tenth Step is: “Continued to take personal inventory and when we were wrong promptly admitted it.” This is an acknowledgement of a characteristic of the alcoholic—the tendency to defensive denial of his own responsibility for the kind of individual he is. That is why this step is here. It is like saying to him, “You have got to be continually on guard that

you don't kid yourself or fool yourself. You have got to be honest with yourself and keep looking at yourself all the time."

The Eleventh Step: "Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry it out." I think that this is an extremely important step, emphasizing as it does the notion that life is characterized by an unending, never-complete task of improving one's relationship with God or the purpose of one's being. I think it says to the alcoholic, "Look, you'll never graduate; there's no end to this; you must continue to search and to study and to improve your knowledge of God." Which is another way of saying that meaning is derived from commitment and re-commitment.

The Twelfth Step is: "Having had a spiritual awakening as a result of these Steps, we tried to carry this message to alcoholics, and to practise these principles in all our affairs." Of course this is a tremendously valuable step. First of all, in its most ideal sense, it is a step that transforms an egocentric, self-centred individual into a person who feels that he has something useful and valuable to give to his fellow human beings. He feels that he has a purpose in his existence—to help people; and this is very useful to him.

The message rubs off

Secondarily, and on a less idealistic plane, the opportunity of trying to convince somebody else that it is a good idea to live soberly often rubs off on the speaker. It is pretty hard to sell somebody on the virtue of staying sober, and to be convincing, without believing it yourself. The other thing the Twelfth Step often does is to enable him to see: "There, but for the grace of God, go I." It reminds him of himself—remembering when.

I would like to talk about some of the other therapeutic advantages of the AA program. The first thing we should consider is that an alcoholic is welcomed into the society of

Alcoholics Anonymous for the very reason that he may be rejected, or feel rejected, in most other segments of society. He is told that he is wanted and needed—loved and respected, perhaps—because he is an alcoholic. His admission card is the very thing that has caused his rejection elsewhere. This has a tremendous impact on the individual. It certainly encourages him—if he wishes—to identify with a group and to acknowledge all the things that he was pretending did not exist.

“You are not alone”

For example, to gain identity in the AA group it is acceptable to tell what a drunk you are and how much you drank. It doesn't matter. In fact, in the early stages you will often hear members bragging about their drinking. Sometimes there tends to be a certain status attributed to this. Of course this dies away very quickly. What is important here is a person gaining recognition and acceptance through admitting—or, if you like, through identification with other people who do admit the presence of defect—that he has problems he had thought were his alone. Up to this time he certainly had tried to deny, to all the other people he interacted with, that he had these problems. I think this is a very powerful therapeutic practice.

Another thing that is important—and I think a lot of people in the “helping” professions should recognize this—is that the alcoholic in AA is allowed to identify *himself* with the disorder rather than being told what is wrong with him. He goes to a meeting, and no one says, “Now your trouble is this, and this is what you should do about it.” What he is more likely to encounter is somebody standing up on a platform and saying, “This is what I did. This is what happened to me. This is the result.” He does not have to listen to too many speakers before he hears someone telling what sounds like his own story. No one is trying to force it on him. No one is trying to push it down his throat. He is permitted to identify. He begins to think, “That's me. I did that.” This strengthens the feeling that he belongs there.

I think most people who conduct psychotherapy recognize the value of creating a situation where the patient is permitted to identify and accept the nature of the disorder rather than being directed and told in an authoritarian way.

Of course there are many other helpful things that evolve as a result of this group contact: the feeling of being wanted and needed—the recognition the individual gets. He is an important person, and he gets a lot of attention. This feeds his pathology initially, but it also facilitates his entry into a meaningful group situation. It provides him with the opportunity to socialize, and this is certainly very important in the early stages of abstinence.

The question the alcoholic so frequently asks with great sincerity—and I sometimes think we do not pay enough attention to this—is, “What will I do if I don’t drink?” His whole life experience is taken up with and dependent on the use of beverage alcohol. When he says, “What will I do if I don’t drink?” it is a profound question. He has this terrible feeling of emptiness, and he is asking: “What is there for me? What is there in life for me?” The fellowship of Alcoholics Anonymous is extremely valuable in helping fill in some of these gaps.

Recovery comes first

Another important feature of the program is the emphasis on the idea that it is an *individual* program. The individual’s recovery is put ahead of everything else. Nothing is more important than getting better. AA members often describe this as a selfish program; I think this is unfortunate, because it creates confusion to use the term “selfish.” It is a fact in the life of an alcoholic that nothing can be more important than recovery, because he will not be able to do anything or perform effectively unless he does recover; this is emphasized in the program.

Another factor growing out of the fact that it is an individual program—and this I think is in recognition of the charac-

teristic defensiveness of the alcoholic—is the idea that “You can’t tell me, but maybe you can show me.” The individual is encouraged to make this program his own by interpreting it in the light of his own experience. I think this makes good sense, not just for alcoholics, but for anyone. If anything is to become meaningful in a person’s life, it can only be because he commits himself to it in relation to his own personal experiences. The AA member who can tell you what it really means to say that he is powerless over alcohol or that he believes in a power greater than himself—when he really begins to know these things—is well on his way to recovery. Because he is encouraged to make it an individual program, he doesn’t have to resist and deny.

“I don’t care what anyone says . . .”

On the other hand, you often hear of situations like this. A speaker will say: “Now this is an individual program and I want you to keep an open mind. What I am saying to you today is only my idea, but, I don’t care what anyone says, you will never be better off unless you do this or that or the other thing.” This will sometimes happen.

Another extremely useful aspect of the program is the “one day at a time” concept. Stop and think about the condition of the alcoholic at the point where he starts to seek recovery. Think a little bit about the kind of person he is. He tends to be the kind of person who wants to do everything all at once. Perhaps he thinks well-being and recovery are measured in terms of achieving all the things that are thought to be important: material well-being, and that sort of thing. At the point where he comes for treatment, he may have lost everything. Getting better and recovering, for him, is a monumental task. Quite apart from the terror of trying to live without alcohol, there is the hopelessness of his condition. His wife may have left him; his family may be scattered around the community; he may have lost his job; he has lost respect. He is in a dreadful state.

I have often found the situation and the condition of the alcoholic patient so tremendously difficult that I have felt almost as depressed and overwhelmed as he. He faces a terrible task.

So, in AA, they talk about living one day at a time. They ask the individual to commit himself—if he can—to the notion of being sober *today*. They point out to him how impossible it is for him to say, “I am never going to drink again,” because he doesn’t know what he is going to do and he cannot predict it with any degree of certainty. It would be a terrifying request if you were to ask him to say he will never drink again. This is asking him to commit himself for a long period of time—forever into the future—to something that is terrifying him right now. Instead, what he is encouraged to do is this: “Look, all you have to do is try the very best you can *today*.” The value in this is that each day successfully completed reinforces his motivation and strengthens him so that the next day will be a little easier.

“Just for today”

AA members live in the present. This is appropriate, not only because it is the only kind of reality there is—the reality of the present—but, when we think of the pathology of the alcoholic, it fits in very nicely because he has dedicated himself to the present in a very real sense. He lives in the world of the present by his constant desire to gain a sense of well-being and a condition of being free from pain right now. The only thing that matters to him is how he feels now. You can say to an alcoholic who is feeling miserable, “Hang on, and tomorrow you will feel better.” He will often say, “I don’t want to feel better tomorrow; I want to feel better right now. The hell with tomorrow.” Encouraging him to live soberly one day at a time is extremely valuable.

In addition to the Twelve Steps of the program, AA has Twelve Traditions. These traditions grew out of the recognition, by early members, of the need for some kind of unifying

philosophy to give them direction in their relationships to the outside world. I would recommend that you read these traditions, because they are extremely wise.* The interesting thing about them is that they do help to keep AA together. Alcoholics Anonymous, you must appreciate, is made up of people who, by their own acknowledgement, are willing to recognize that they are not the most mature people in the world. The very fact that this magnificent organization has survived and grown is amazing; the AA members call it a miracle. They will often say, "To think a bunch of nuts like us could be responsible for a thing like this."

The importance of anonymity

I would like to mention only the last tradition, the twelfth. This is the tradition of anonymity. Anonymity is not designed to protect a person from the embarrassment of being recognized as a member of AA. Rather, it is to remind him constantly of the necessity of putting principles ahead of personalities. Today, when so many people are recognizing AA and are going out and wooing AA, it is tremendously tempting for some AA members to try to become "Mr. AA." Many people in AA have the the opportunity of gratifying some unhealthy impulses by being the centre of attention and getting recognition. They become speakers in churches, they become speakers to service clubs, and so on. At times they come perilously close to compromising their position.

Once, when I participated in an AA program on television, some of the panel members started talking about drinking and driving and the age at which young people can legally obtain alcohol. As private citizens, they had every right to talk about those issues. As AA members they had no right to talk about them because, as the Tenth Tradition says, AA "has no opinion on outside issues."

I would like to say something to professionals, about work-

* The Twelve Traditions are reprinted on p. 19.

ing with AA. It is an extremely valuable thing to appreciate the contribution that AA can make. As this appreciation grows, more and more people are trying to work with AA. First of all, I have found over the years that it is very important to try to get to know the various AA groups in your community. Get to know some of the members. Take the trouble to show them that you want to learn from them. No matter how knowledgeable you are, you are probably never so knowledgeable that you can't learn something from them. When you go to their meetings, in humility and with an eagerness to learn, I think you will find that your acceptance will be very great.

Secondly, you should resist the temptation they will expose you to—making you an authority. A clergyman, a doctor, a nurse, or anyone else who shows any interest in AA, will very quickly be asked (if he is a reasonable person at all) to become a speaker. The first thing you know, you can have a glorious time going around the countryside speaking to AA groups. This is very gratifying because, if you are at all perceptive, you will quickly know what to say. You will tell them what a great bunch of people they are, how wonderful they are. They in turn will tell you how wonderful *you* are, and you will really feel good about it all. I think that this is one thing that a person needs to be cautious about, because you become too familiar and often your usefulness in the community is impaired by this kind of strong identification.

Look out for evangelists

Thirdly: if you want an AA member to help you, I think it is fair to say that you should use some caution in choosing the person. Growth in AA usually takes time. If you want an AA helper, I think you would be very wise to contact a man who has had some experience—say five years, or two years at least. One of the things you will often encounter is the “AA evangelist.” Very often he is somebody who has been in AA for six or seven months or less. He is tremendously enthusiastic; this is good for him, and it helps him a great deal. However, the

fact of the matter is that this man still has a lot to learn. He is going through a process that the older members recognize. The older men help him with this; but in terms of establishing a relationship with your organization, he is not necessarily the best man to deal with.

Finally, the only other thing I would advise you to do in working with AA is to be scrupulous in respecting the traditions of the program yourself. For example, never take an AA member's anonymity for granted. He may be completely indifferent to it, but that is up to him. It is not up to anyone else. Whenever you are in the position of introducing an AA man *as* an AA man, simply say "This is Bill." It is up to him to decide if he wants to be known any other way. Do not be careless of the things that are important in the AA program.

L'auteur est le Directeur Régional de l' "Addiction Research Foundation" pour le District du Lac Erie; il travaille en coopération avec "Alcoholics Anonymous" depuis 1950 environ. Dans cet article, il décrit la manière dont AA a débuté, donne un aperçu général de son programme, en ajoutant quelques commentaires sur les raisons pour lesquelles cet organisme fonctionne aussi bien qu'il le fait. Il offre en outre quelques suggestions à l'adresse des professionnels qui peuvent être appelés un jour à travailler de concert avec AA.

AA's "Serenity Prayer"

God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.

(Adapted from the original of Reinhold Niebuhr)

The Twelve Traditions of AA

1. Our common welfare should come first; personal recovery depends upon AA unity.
 2. For our group purpose there is but one ultimate authority . . . a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants . . . they do not govern.
 3. The only requirement for AA membership is a desire to stop drinking.
 4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
 5. Each group has but one primary purpose . . . to carry its message to the alcoholic who still suffers.
 6. An AA group ought never endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
 7. Every AA group ought to be fully self-supporting, declining outside contributions.
 8. Alcoholics Anonymous should remain forever non-professional, but our service centres may employ special workers.
 9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
 10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
 11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
 12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.
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Getting in Touch with AA

By "George S."

In most parts of Ontario, AA is not hard to find: at last count—in January, 1969—there were 450 groups in the province. In the larger centres, there is an "Alcoholics Anonymous" listing in the telephone book; in the smaller centres, if there is no listing in the telephone book, the local police and clergy often know how AA can be reached. If all else fails, AA has a post office box in Toronto; if an inquirer writes to that box from anywhere in Ontario, he can be told how to get in touch with the group nearest him. The address is:

Ontario General Service Committee,
Attention Liaison Secretary,
Box 686,
Adelaide Street Post Office,
Toronto 1.

Anybody who has any interest in AA is welcome to an open meeting, whether he intends to join or not. If a prospective member needs a little moral support to go to his first meeting, it can generally be arranged; but there is nothing to prevent a person from walking in on his own.

The first AA meeting I went to—about ten weeks ago—I was a little shaky, my clothes were rumpled and my shoes could have used a shine. I felt a little out of place among all those fit-looking, well-dressed people. I soon learned that I need not have felt so: most of them were in pretty rough shape themselves when they came to their first meeting. I found out later that many AA members make a point of being well-turned-out, especially at meetings; it's part of their own program of getting their lives in order again, and it encourages the other members.

I felt pretty angry after my first meeting, because nobody had spoken to me except the man who was at the door when

"George S." is a member of Alcoholics Anonymous.

I came in. It turned out that there were one or two things I didn't know, or had overlooked. The first was that I hadn't spoken to anybody either. The second was that many AA members attend meetings of groups other than their own, so many of the people who were there that night were probably strangers themselves. The third was that old AA members know all about people like me, anyway, because they were once like me themselves. They know it isn't easy, at first, for an alcoholic to come out of his shell unless he has had a few drinks; they're in no hurry; when I did decide to come out of my shell, they were right there.

Al-Anon and Alateen

Al-Anon is a fellowship of people who are married to alcoholics, who help each other with their own problems. Alateen is a similar fellowship of the teen-aged children of alcoholics. These are "parallel" organizations to AA, not part of the AA structure. As of January, 1969, there were 156 Al-Anon groups and 32 Alateen groups in Ontario.

In some of the larger centres, there is a listing for "Al-Anon Family Groups" in the telephone book. If there is not, it is worthwhile to call the "Alcoholics Anonymous" number. Again, if all else fails, Al-Anon has a mailing address:

Al-Anon Family Groups,
Box 474,
2439 Eglinton Avenue East,
Scarborough, Ontario.

Alateen is part of Al-Anon Family Groups, and may be reached in the same way.

In areas where there are no Al-Anon groups, there is no reason why the wife, husband or child of an alcoholic can't come to an open meeting of AA and talk with some of the AA members; there's a lot of free help available in any AA group.

The Credibility Gap in the Illicit Drug Market

By Joan A. Marshman and Robert J. Gibbins

The widespread availability of cannabis preparations, LSD (lysergic acid diethylamide), and other hallucinogenic agents has given rise to extensive research in many areas. To a significant extent, the interpretation of much sociological and clinical data is predicated on the assumption that the drug user can correctly identify the chemical or chemicals that he has used. Relevant to this research picture, certain questions are being raised with increasing frequency:

—physicians, social workers, and other community consultants are asking whether the causative factors of particular “bad trips” lie chiefly in the drug user himself, in the circumstances under which the drug is taken, or in the product used; and

—drug users are questioning the prevalence of “burns”—the misrepresentation of a drug-free or low-potency product—and the incidence of sale of one hallucinogenic agent as another.

In the belief that a better knowledge of the composition of the products on the illicit drug market is fundamental to many areas of research and treatment, the Addiction Research Foundation has established a program to analyse these products. The development of this laboratory—the acquisition of basic equipment and reference samples, and the establishment of standard procedures—took place over the first half of 1969.

Dr. Marshman is a research scientist in psychological studies, and Dr. Gibbins is Associate Research Director (Psychological Studies) at the Addiction Research Foundation in Toronto. The authors gratefully acknowledge the technical services of laboratory assistants Gail Stewart and Ruth Berg in the analytical work reported, and the co-operation of the Food and Drug Directorate, Ottawa, in the provision of reference samples.

Currently, our concentration is on qualitative analysis—the identification of the drug components in the product—and we expect that this may later be extended to include quantitative analysis as well. The techniques we use include chiefly color tests, thin-layer chromatography, and infra-red spectrophotometry, with some use of gas-liquid chromatography.

This report deals with the data we collected during the first eight months of 1969. In this period we completed analyses of 222 drug samples from various parts of Ontario. Of these samples, 64 per cent came from downtown Toronto, 18 per cent from other areas of Toronto and adjacent municipalities, and 18 per cent from other parts of the province. Of the 222 samples we analyzed, we found that 23 per cent were LSD, 9 per cent were mixtures apparently resulting from the unsuccessful synthesis of LSD, 13 per cent were hashish, 11 per cent were marihuana, 11 per cent were methamphetamine, 6 per cent were MDA (3, 4-methylenedioxyamphetamine), 10 per cent were other drugs, 13 per cent were not drugs at all, and 4 per cent we could not identify.

A considerable discrepancy

A comparison of the determined composition of the drug samples with their alleged composition indicated a considerable discrepancy. Of the 222 samples, the alleged composition of 197 was made known to us. Of these 197 samples, we found that only 61.9 per cent contained the drug that was alleged to be present.

Of the samples alleged to be hashish, 100 per cent were hashish; of the samples alleged to be LSD, 68 per cent contained LSD; of the samples alleged to be marihuana, 67 per cent contained marihuana; of the samples alleged to be methamphetamine, 64 per cent contained methamphetamine; of the samples alleged to be MDA, 57 per cent contained MDA; of the samples alleged to be mescaline, none contained mescaline. Two samples alleged to be stramonium contained no stramonium.

In addition, 20 samples were alleged to contain a mixture of drugs: hashish with opium, LSD with cocaine, LSD with methamphetamine, LSD with atropine, or methamphetamine with strychnine. In no case could we confirm the presence of a second drug.

“LSD” and “mescaline”

Two groups of samples are worthy of particular attention: those alleged to contain LSD, and those alleged to contain mescaline. Of 57 samples alleged to contain LSD, we found that about half—54 per cent—contained LSD in a relatively pure form. The remainder contained a large proportion of impurities or did not contain LSD at all. We considered samples containing LSD together with detectable quantities of two or more chemically related substances to be “impure LSD;” on this basis, we found that 14 per cent of the samples alleged to be LSD were impure. Another 21 per cent of the alleged LSD samples were mixtures apparently resulting from an unsuccessful attempt to synthesize LSD; 9 per cent of the samples contained no drug at all, and 2 per cent we could not identify.

Of 23 samples alleged to contain mescaline, none of them did; but the incidence of LSD and related compounds is striking: 30 per cent of the samples were relatively pure LSD, 13 per cent were “impure LSD” as defined above, 26 per cent were mixtures apparently resulting from an unsuccessful attempt to synthesize LSD, 9 per cent were MDA, 4 per cent were atropine, and 17 per cent contained no drug at all.

In regard to the 36 samples alleged to be marihuana, some of these were in fact marihuana, with a high cannabinoid content—“good grass,” as it would be termed on the street; some were marihuana with a low cannabinoid content, some were marihuana cut with other substances, and some contained no marihuana at all. It would take a botanist to determine what the “other substances” were, and we have no botanist on staff. Some of it appeared literally to be grass—lawn clippings; some

of it looked like hay and smelled like hay. Our figure of 64 per cent for samples that "contained marihuana" includes all the samples that contained any marihuana at all.

In the light of these findings, it is clear that a significant discrepancy exists between the alleged composition and the real composition of the products of the illicit drug market. We believe that the implications of this discrepancy are relevant to both research and treatment. In the first place, it would appear that interview or questionnaire data about the prevalence of the use of various drugs must be interpreted with considerable caution. Secondly, since rational treatment of adverse drug reactions depends on knowing what drug or drugs the patient has taken, it is apparent that there are pitfalls in the emergency medical treatment of these reactions. Finally, our data suggest that theoretical explanations for the use of specific drugs, based on their pharmacological effects, cannot be applied to "street" drugs without suitable modification.

Les auteurs donnent un compte-rendu des résultats atteints au cours des huit premiers mois d'opération d'un laboratoire dont la fonction est d'analyser les narcotiques vendus clandestinement dans la région de Toronto et dans d'autres parties de l'Ontario. Ils ont découvert qu'il existait une différence considérable entre la présumée composition des échantillons de narcotiques qui leur ont été soumis et leur composition véritable. Ils avancent que cette découverte aura des répercussions dans le domaine de la recherche sur les narcotiques ainsi que dans la solution des problèmes que pose la narcomanie.

The Effects of Marihuana On Human Beings

By Norman E. Zinberg and Andrew T. Weil

Unlike most Bostonians on April 19, 1968, we celebrated Patriots' Day by violating Section 200 of Chapter 94 of the General Laws of the Commonwealth of Massachusetts. The law reads: "A physician or a dentist, in good faith and in the course of his professional practice only, for the alleviation of pain and suffering or for the treatment or alleviation of disease may prescribe, administer, and dispense narcotic drugs. . . ." What we did on the evening of the 19th was to administer marihuana (a narcotic drug under Massachusetts law) to volunteer subjects, not for the alleviation of suffering or disease, but in order to find out what marihuana does to people who smoke it. The legislators of the Bay State had simply not provided a statute to authorize this research.

The event itself, which took place in a pleasant laboratory at the Boston University School of Medicine, was of greater scientific than legal consequence because it was the start of the first human experiments with marihuana ever designed according to modern principles of drug testing.

We had received permission to investigate the drug only after a full year of the most frustrating negotiations with Federal agencies and the administrative bureaucracies of two universities (B.U. and Harvard). We were not about to give up when our mid-April deadline came around because of an oversight in state law, even though our lawyer warned us that we might be

Dr. Zinberg is now a special research fellow in the Department of Psychiatry at Tufts University Medical Center in Boston. Dr. Weil was assigned in July to the Office of Program Planning and Evaluation of the (U.S.) National Institute of Mental Health. This article first appeared in *The New York Times Magazine* of May 11, 1969. Copyright © 1969 by The New York Times Company. Reprinted by permission.

prosecuted. (Shortly after we began work, he succeeded in extracting a promise of immunity from prosecution from the Attorney General of the Commonwealth, who hinted wryly that the last such request he had received concerned the ill-fated *Titicut Follies*—a film documentary about the state prison for the criminally insane at Bridgewater, Mass.)

Nine weeks and some 60 marihuana cigarettes later, we had obtained the first “hard” data on the acute effects of the drug on human beings, and we then began to analyse our results. These were published last December in a long article in the journal *Science* and have generated considerable discussion.*

Our report in *Science* began: “In the spring of 1968 we conducted a series of pilot experiments on acute marihuana intoxication in human subjects. The study was not undertaken to prove or disprove popularly held convictions about marihuana as an intoxicant, to compare it with other drugs, or to introduce our own opinions. Our concern was simply to collect some long overdue pharmacological data.”

“Seriousness” overrated?

Nevertheless, the report has given rise to vigorous debate about the harmfulness of marihuana. In both scientific and non-scientific circles our results have been taken to indicate that the “seriousness” of the drug has been overrated.

For example, in an editorial, titled “Boston Pot Party,” *The New Republic* wrote: “While pot heads may legitimately ask, ‘So what else is new?’ the study may have a pacifying influence on parents and officials who fear the drug on the basis of unsubstantiated horror stories. According to the *Science* report, ‘no adverse marihuana reactions occurred in any of our subjects.’” And our experimental findings have already been introduced

* Weil, Andrew T., Zinberg, Norman E., and Nelsen, Judith M., “Clinical and Psychological Effects of Marihuana in Man,” *Science*, Vol. 162, December 13, 1968, pp. 1234-1242. For some comment, see “Letters,” *Science*, Vol. 163, March 14, 1969, pp. 1144-1145.

as evidence in several court challenges to the current harsh laws on possession of marihuana.

Consequently, we feel an obligation to explain what we think is the significance of our study as well as to point out what is and is not known about the effects of marihuana.

Two kinds of information

It is worth reiterating that very little is reliably known about the effects of marihuana. In studying a drug of this sort there are two ways a researcher can go about getting information: he can ask users of the drug what effects they get from it or he can actually give marihuana to subjects in a laboratory and watch what happens.

The trouble with the first kind of information is that it is grossly unreliable. As we have learned more about drugs that affect the mind, it has become all too clear that the pharmacological action of the drug (that is, what a pharmacology text says it should do) is but one of three factors that determine how a given person will react to that drug on a given occasion. The other factors are called "set" and "setting," and they are at least as important as the drug. Set is the psychologist's term for an individual's expectations of what a drug will do to him; it includes much of what we commonly call "personality." Setting is the total environment—physical and social—in which a drug is taken.

Information from users

It is quite possible for the combined effects of set and setting to overshadow completely the pharmacological action of a drug. Thus, a barbiturate, which pharmacology texts tell us is a "sedative," can produce stimulation under certain conditions of set and setting. And amphetamine, a "stimulant," can cause sedation under other special circumstances. The vaguer and less predictable are the pharmacological effects of a drug, the greater is the importance of set and setting. Hence the danger of relying on information about marihuana from people who

use it. What they say may apply to them, but whether it is pharmacologically accurate and can be applied to other persons is never clear.

Unfortunately, nearly all of the voluminous scientific literature on marihuana consists entirely of this kind of unreliable information. It is a collection of rumor, anecdote, and second-hand accounts. Much of it has been culled from other countries where set and setting are drastically different from set and setting in, say, an American college community. In India, for example, hemp drugs (usually more potent than U.S. marihuana) are in great disrepute and are used only by the lowest socio-economic classes, often as an escape from the dreariness of everyday life. Observations on these users simply have no relevance to the situation in our country.

Information from experiments

This is not to say that experimental laboratory information is always "right," and information from users is always "wrong." In fact, laboratory information has its own problems. The essence of the experimental method is manipulation of the environment so that an observed effect may be ascribed with some confidence to a known cause (in this case the administration of a drug).

Consider a simple example. About nine out of ten marihuana users we have interviewed (we have now interviewed many hundreds) have told us they are certain marihuana dilates the pupils of their eyes when they are high. An even higher percentage of law-enforcement agents have told us the same thing. But pupil size depends on other things besides what drug you may happen to have inside you. One obvious determinant is the surrounding illumination: The dimmer the light in a room, the larger are one's pupils. A less obvious factor is the distance at which one's eyes are focussed; pupils constrict as part of the eye's accommodation for near vision.

Therefore, if a researcher wishes to measure the effect of a drug on pupil size, he is obliged to hold the other factors con-

stant—to *control* them. He must measure the pupils before and after administration of the drug under constant, standard illumination with the eyes focussed at a constant, standard distance.

Observations made by users or law-enforcement agents at pot parties are not likely to be this scrupulous. When we finally did the appropriate experiment in Boston, we were not surprised to find that pupil size was not changed at all by marihuana. (Since the lighting at marihuana parties is often dimmer than usual, it is also not surprising that participants commonly have large pupils.)

The problem with experiments

The curious problem of the experimentalist, however, is that as he controls the laboratory environment more and more carefully, so as to maximize his confidence in ascribing observed effects to known causes, his laboratory becomes less and less like the real world, which is what he set out to study. Indeed, control can proceed to the point that the experimental results are scientifically impeccable, but their relevance to anything in the real world is lost. Then, if someone comes along and says, "So what?"—as happens all too infrequently in science—the experimentalist will be stuck for an answer.

What little laboratory research has been done on marihuana is defective in just this way. Recently a chemical called THC (for tetrahydrocannabinol) has been isolated from marihuana and synthesized. To date, it has not been established that this chemical is the sole active ingredient of hemp, but it has been so advertised in the scientific literature. In 1967 this drug was given to human beings in a well-designed experiment in the Addiction Research Center in Lexington, Ky. With high doses (probably many times higher than users commonly absorb from marihuana cigarettes) the drug caused psychotic reactions in subjects recruited from a prison population of former opiate addicts.

This result was widely interpreted in both scientific and lay

journals to mean that marihuana is not such a harmless drug after all—a wholly unjustified conclusion. The only legitimate conclusion is that unusually high doses of a compound that may or may not reproduce the effects of marihuana cause acute psychotic reactions in former opiate addicts. No one spoke up with the “So what?” that was called for.

Psychotic reactions rare

In our experience, and that of all users we have talked to, true acute psychotic reactions to marihuana are rare to the point of being psychiatric curiosities—at least in persons who have not previously taken hallucinogenic drugs like LSD. This real-world observation casts further doubt on the relevance of the findings with THC.

It would seem that the marihuana researcher must steer a middle course between his desire for scientific accuracy and his obligation to make his findings relevant to the world beyond his laboratory. We made a great effort to do this in our Boston University experiments.

One of our first decisions was to administer the drug to subjects in the form of cigarettes. Up to now, most researchers have given the drug in some form to be swallowed. Their argument is that doses are hard to standardize in smoking since different subjects inhale in different ways. In other words, the results are more “scientifically accurate” if the drug is swallowed.

Smoking and swallowing

We would agree if we felt the effects of the drug were the same regardless of route of administration. But, in fact, it appears that swallowed marihuana is qualitatively different from smoked marihuana. We have collected massive evidence from interviews suggesting that marihuana causes more powerful, longer-lasting effects when it is eaten, and this does not appear to be due simply to differences in dose. Possibly, components of the plant that are destroyed by the heat of smoking get into the body when the drug reaches the stomach. And

since in the real world marihuana is usually smoked, we were willing to risk some inaccuracy in standardizing dose in order to preserve the relevance of our data.

We also used doses of marihuana that made users very high in their own judgment; we did not use the very high doses of THC that some researchers have used in the past (as much as ten times the 18 mgm. of THC we estimated subjects received in our experiment as a high dose of marihuana), resulting in florid psychotic or other toxic responses.

The experimental group

In order to minimize variation in the set of our subjects, we used, primarily, a group of nine young men who had never tried marihuana previously; their attitudes toward the drug were explored before the start of testing in an intensive psychiatric interview. (Interviews were repeated six months after the end of the experiment to see whether any of these subjects had "moved up" to other drugs; only two of the nine had tried marihuana subsequently and those on only one occasion each. None had tried any other psychoactive drugs.)

The setting of the experiment was as "neutral" as possible. Subjects were made comfortable and secure in a suite of laboratories and offices but no attempt was made to provide them with an enjoyable experience. Interactions with the staff were few and formal, and no subject was permitted to discuss the experiment until he had finished it.

In properly designed research, the number of subjects needed is determined entirely by the kinds of data one wants to collect. For our purposes, nine marihuana-naïve subjects were more than sufficient. Each was tested four times. First we held a practice session with tobacco to teach a standardized technique of inhaling and to allow subjects to become familiar with the tests. By instructing the subjects to hold each inhalation for 20 seconds as timed by a stop-watch, we achieved fair standardization of intake. Five volunteers never got past the practice session. Although they had regarded themselves

as heavy cigarette smokers, they experienced acute toxic nicotine reactions during this regime of rigorous inhalation. (Indeed, these nicotine reactions were the most impressive physiological responses of the entire experiment.)

Then came three "drug" sessions in which subjects smoked—in random order and at weekly intervals—either high or low doses of marihuana, or inert placebos, prepared from portions of male hemp stalks that contained no pharmacological activity. These sessions were "double-blind"—that is, neither we nor the subjects knew what was being smoked each evening—a precaution against possible contamination of the results by whatever preconceptions we, ourselves, held about marihuana. No previous research with the drug had employed this necessary safeguard.

The comparison group

We also studied a comparison group of eight heavy users of marihuana who were tested only once and only on high doses. (We could not use the double-blind method here because no one has yet found a placebo good enough to fool heavy users.) Interesting differences in the reactions of the two groups showed up; we will discuss them in a moment.

As a result of the care we took in planning these experiments, our results, we think, have more to say about marihuana than those of all earlier studies. Here is what we did, starting on Patriot's Day, 1968.

When we sat down to plan the experiments, we outlined three major areas of investigation. We wanted to clarify the effects of marihuana on the body during a high; we wanted to study psychological performance while under marihuana influence; and we wanted to assess the long-range effects—if any—of heavy marihuana use. Our first tactical decision was to postpone study of the third area simply because accurate measurement of the effects of chronic use of a drug requires far more elaborate procedures and far more time than we had available.

In planning experiments on acute physical effects, we were faced with the problem of not knowing what to look for. Unlike most drugs that affect consciousness, marihuana does not seem to do very much to the body, and we had few clues as to what tests would be likely to pay off. We looked at heart rate because previous studies had consistently found an increase. We studied pupil size because no one had ever done the simple measurement described above. We examined blood-sugar levels because low blood sugar has been invoked as an explanation of the increased appetite users commonly report when they are high. We looked at the whites of the eyes because marihuana allegedly reddens them. And we measured respiratory rate because it is an easily measured vital sign and depression has been reported.

“Other parameters”

We could have studied other physiological variables (such as level of adrenalin in the blood) but to do so would have been a random approach based on no hypotheses. We feel strongly that mindless experiments of that sort are inconsistent with the principles of good laboratory investigation and that results from such studies merely clutter the scientific literature with facts of obscure significance. Hence our amusement when a biochemist on one of the Harvard committees that got itself into endless muddles over our proposal criticized our experiments for lack of sophistication in that they did not include measuring of “other physiological and biochemical parameters.” (Another member of the committee asked why we couldn’t do the experiments on rats or pigeons to avoid controversy.)

Physiological results

Our results were clear-cut. Marihuana caused a moderate increase in heart rate, but not enough to make subjects conscious of a rapid pulse, and it reddened whites of eyes. It had no effect on pupil size, blood sugar, or respiratory rate. Possibly

the drug has a few other effects on the body (we think it decreases flow of saliva and tears and are about to start new experiments to document these changes), but it is unlikely that other major effects will be found.

The significance of this near-absence of physical effects is two-fold. First it demonstrates once again the uniqueness of hemp among psychoactive drugs, most of which strongly affect the body as well as the mind. Thus the mental effects of LSD are accompanied by a panoply of neurological and physiological changes including widely dilated pupils, altered reflexes, abnormal reactions of involuntary muscles, and so forth.

Second, it makes it unlikely that marihuana has any seriously detrimental physical effects in either short-term or long-term usage. The influence of marihuana smoke on the lungs is unknown, but aside from the possibility of local irritation, marihuana has not been accused of having adverse medical effects, even in countries like India and Egypt where government agencies actively campaign against the drug. As recently as 1967, on the basis of no evidence whatever, the American Medical Association told physicians in a statement in its *Journal* on the hazards of marihuana that "hypoglycemia" (chronic low blood sugar) was a consequence of repeated use of the drug, but our research has undercut that claim. All in all, we think it is fair to say that in terms of medical dangers only, marihuana is a relatively harmless intoxicant.

Psychological tests

In approaching the question of psychological effects of the drug, we again had a difficult time deciding what tests to use. The great mystery about marihuana seems to be the enormous discrepancy between its subjective and objective mental effects. Persons who smoke the drug experience great changes in their consciousness, but they seem to have nothing to show for it. Previous researchers have found that if tests are made complicated enough or if doses of the drug are made high enough, subjects will show across-the-board impairments in psycho-

logical performance, especially if they are not very familiar with the drug. But these impairments are nonspecific; they are the sort seen with any drug that influences alertness, for example. No one has shown any specific way in which a person, high on marihuana, is different from one who is not.

We used several standard psychological tests and one or two unorthodox ones. The Digit Symbol Substitution Test is

1	2	3	4
-	1	3	L

5	6	7	8	9
U	O	Λ	X	=

2	1	3	7	2	4	8	1	5	4	2	1

1	5	4	2	7	6	3	5	7	2	8	5

6	2	5	1	9	2	8	3	7	4	6	5

a simple test of cognitive function often used on I.Q. tests. The cut shows an example of the Digit test; on a signal from the examiner the subject is required to fill as many of the empty spaces as possible with the appropriate symbols (top two lines). The code is always available to the subject during the 90-second administration of the test.

The Continuous Performance Test measures a subject's capacity for sustained attention. In our study, the subject was placed in a darkened room and directed to watch a small screen upon which six different letters of the alphabet were flashed rapidly and in random order. The subject was instructed to press a button whenever a specified critical letter appeared. Errors of commission and omission were counted over a five-minute period. The test was also done with a strobe light flickering at a distracting rate. Normal subjects make no or nearly no errors on this test either with or without strobe distraction, but sleep deprivation, organic brain disease and certain drugs (like chlorpromazine, an antipsychotic drug) adversely affect performance.

A third standard test we used was the Pursuit Rotor, in which the subject's task is to keep a stylus in contact with a small spot on a moving turntable. It measures muscular co-

ordination and attention. Finally, we collected a "verbal sample" from each subject before and after he smoked the test cigarettes. The subject was left alone in a room with a tape recorder and instructions to describe "an interesting or dramatic experience" in his life until he was stopped. After exactly five minutes he was interrupted and asked how long he thought he had been in the recording room. In this way an estimate of the subject's ability to judge time was also obtained. (After intoxication, time sense was significantly slowed. Some subjects guessed the five-minute period to be as long as 10 or 12 minutes.)

Why tests were chosen

The first three tests were chosen because they are standard tests for specific mental functions we thought might be altered during a marihuana high. The verbal sample was taken because we had a hunch—on the basis of careful interviews with and observations of chronic users—that speech undergoes changes when one is high, and we wanted to see if we were right.

In several ways the results of the psychological tests were surprising. Our first observation was that persons who had never tried marihuana previously had minimal subjective reaction to the drug in our neutral setting—even after smoking high doses that made their hearts beat faster and their eyes turn red. They simply did not get high. By contrast, all the users got high on the same dose, even though many of them thought our setting was extremely negative and were set not to have a pleasant time.

A demonstration session

We were struck by the difficulty of recognizing when a subject is high unless he tells you that he is. As a splendid example of the problem, we should mention that at the end of our study we arranged a demonstration session, in which two of our user subjects volunteered to go through the tests again

for the benefit of a party of observers from the Federal Bureau of Narcotics and Dangerous Drugs, the Massachusetts Bureau of Drug Abuse and Drug Control, and several lawyers.

Most of the observers had never seen anyone smoke marihuana before. Their universal reaction was extreme disappointment—disappointment that nothing happened. It was not clear what they had expected to happen, but they had expected something. When our subjects continued to behave normally and to go through the tests without difficulty, the observers became restive. “Are you sure they were inhaling right?” one asked. “Are you sure the marihuana is any good?” said another. The subjects, meanwhile, both said they were quite stoned. When asked to rate how high they were on a scale of one to ten, with ten being the highest they had ever been, they rated themselves at eight and nine.

Naive subjects did worse

Both groups did exactly the same on the Continuous Performance Test after smoking the drug as before, which led us to conclude that attention as measured by the C.P.T. is unaffected by marihuana. On the Digit Symbol Substitution Test an interesting difference appeared. The naive subjects did worse after smoking, and the degree of impairment was related to the dose smoked: A little made scores go down a little; a lot made scores go down a lot. Here again is the nonspecific effect noted above.

But the users improved slightly on the D.S.S.T. when they were high—even though they started out from good baseline scores. They showed a similar improvement in the Pursuit Rotor test. Especially interesting to us was the surprise users expressed on finding how well they could perform when stoned. Most of them were very apprehensive about taking the tests after smoking because they felt so high; some even asked to be excused from them. But when they tried, they were delighted to find they could perform well. This reaction is quite the opposite of the false sense of improvement subjects have

under some psychoactive drugs (like alcohol) that actually impair performance.

What do these results mean? Apparently, getting high on marihuana is a much more subtle experience than getting high on alcohol; perhaps it is something that must be learned, so that most persons who take the drug for the first time cannot recognize the changes it causes in their consciousness.

This hypothesis is consistent with the evidence that marihuana seems to affect little in the brain besides the highest centres of thought, memory and perception. It has no general stimulating or depressive action on the nervous system (hence the absence of neurological as opposed to psychological changes during a high), no influence on lower centres like those controlling the mechanical aspects of speech and coordination (hence no slurred words or staggering gait). As a result it seems possible to ignore the effects of marihuana on consciousness, to adapt to them, and to control them to a significant degree.

If you pour enough alcohol into a person who has never before had alcohol, he may not have a pleasant time, but at some time he will be unable to ignore the fact that he is intoxicated: he will *feel* that his nervous system is behaving in an abnormal fashion. Not so with marihuana: A first-time smoker can consume enormous amounts and have the physical reactions to the drug without any mental effects at all.

Compensating for effects

As with most intoxicants, as one becomes familiar with alcohol, he can learn to compensate for the drug's adverse effects on performance—but only to a point; alcohol imposes absolute limits on the speed of nervous functioning by its direct pharmacological action. Again, not so with marihuana: Users appear to be able to compensate 100 per cent for the nonspecific adverse effects of ordinary doses of marihuana on ordinary psychological performance (including driving, according to the findings of a soon-to-be-published study con-

ducted by the Department of Motor Vehicles of the State of Washington and the University of Washington).^{*} A person intoxicated on alcohol, on the other hand, has a hard time acting sober.

Again the question arises: How is a person high on marihuana psychologically different from one who is not? And there is still no answer. In fact, the only way to know someone is high on marihuana is still to have him tell you so.

Effects on speech

Our hunch that speech might be an area in which to find a change seems to have paid off, but further experiments must be done before we can spell out the exact nature of the change. We were able to show in our user population that the nature of a verbal sample changed in several important ways after the subjects smoked marihuana. For example, before smoking, in response to the instructions, most subjects told a story about past events. After smoking, the same subjects abandoned narrative format and tended to talk about the present—things going on in their immediate environment. They also tended to become more intimate and to think in free associative patterns rather than according to everyday logic. The imagery they used became less concrete and more dreamlike.

To illustrate this point, here are two excerpts from one subject's verbal sample before and after he smoked marihuana:

Predrug: "Well, I guess the most interesting event recently that I can think of would have to do with turning my draft card in, which happened Jan. 29, 1968, and—uh—one of the most interesting things to me about handing in my draft card to the Resistance was that I hadn't planned to do so before I did it. . . ."

Postdrug: ". . . Oh—[clears throat]—you know, the tro-

^{*} Crancer, Alfred, *et al.*, "Comparison of the Effects of Marihuana and Alcohol on Simulated Driving Performance," *Science*, Vol. 164 May 16, 1969, pp. 851-854.

... the trouble is that—uh—the present is more interesting now than events in the past. I mean the idea of sitting here and talking about something that's already happened instead of—uh—you know—instead of happening now—instead of just being now—the present—is kind of ridiculous. . . .”

We are going to pursue these differences in an expanded investigation of language under marihuana influence and also want to search for other possible differences between being straight and being high—particularly in the areas of immediate memory and “secondary perception,” that is, what the brain decides to do with incoming sensory information. In the meantime, what can we say about the dangers of marihuana from a psychological standpoint? From our own study and from other studies now in progress, it would seem—in short-term usage only—that usual doses of marihuana do not impair a user's ability to carry out successfully a wide range of tasks of ordinary complexity. But higher than usual doses, especially in novice smokers, might be expected to cause performance decrements.

Long-range effects?

The real debate about the merits or evils of marihuana ought to focus on the long-range psychiatric effects of the drug, if any. This is the main area of controversy because there are still no data at all. We have no information on the subject from our own study, and we regret the continuing lack of any good research on it.

What is needed is a decent prospective study of persons—say, medical students—who are setting out to become regular marihuana users, matched against a similar group not using the drug. Each group should be followed and tested serially for five, ten, or more years. If such a study is not organized soon, it may be too late. Marihuana use is becoming so extensive in some sections of the country that within certain age ranges, persons who do not use the drug are so unusual as to constitute what statisticians call a biased sample.

One of the results of not having had any real information on the drug for all these years has been the development of a vicious circle in which administrators of scientific and government institutions feel that marihuana is dangerous. Because it is dangerous, they are reluctant to allow work to be done on it. Because no work is done, people continue to think of it as dangerous.

We hope that our own study has significantly weakened this trend. In view of the ease with which we carried out the tests once they were under way and the lack of harm to any of the participants, we hope that our project will be used as a precedent.

We also hope that state laws obstructing marihuana research will rapidly be amended. For society will never be able to develop an effective and sensible policy on the use and abuse of psychoactive drugs unless it permits the free collection of information on the actual effects—whether harmful or beneficial—these drugs have on the mind.

Political questions

Anyone attempting research in an area as hotly immersed in controversy as marihuana use knows that he cannot expect his findings to be received with neutrality or scientific objectivity. Nevertheless, even with this in mind we have been surprised at the extent to which we are asked to jump from one experiment concerning a small area of information about marihuana into large political and philosophical questions.

We are repeatedly asked, "Should marihuana be legalized?" or, "If it is 'harmless,' do you advocate people trying it?" We don't know the answers. The first question is out of our ken and neither question could be answered until our most important recommendation is implemented. What we proved is that research can be done with this substance. What we recommend is that individuals and institutions in conjunction with the legal authorities do it.

Les auteurs traitent de la signification d'une expérience qu'ils ont effectuée à l'Université de Boston en 1968, au cours de laquelle ils ont administré de la marihuana à des sujets humains. Le rapport de cette expérience a officiellement paru dans le numéro de décembre 13, 1968, de la revue *Science*. Dans cet article, les auteurs examinent certaines difficultés propres à la recherche sur les narcotiques en général et sur la marihuana en particulier; ils décrivent comment ils ont conçu et poursuivi leurs expériences, ce qu'ils ont découvert et la portée de leurs résultats; ils suggèrent aussi certains domaines qui pourraient faire l'objet d'études par les chercheurs de demain.

Summer Course, 1970

The Addiction Research Foundation of Ontario will offer its ninth annual summer course on Alcohol and Problems of Drug Dependence at Brock University, St. Catharines, in co-operation with the university. The two-week residential course begins May 31st and ends June 12th.

The course is designed to provide basic information for those who are called upon in their professional work to deal with problems related to the misuse of alcohol and other drugs. It is planned especially for those who are engaged in developing and supervising programs that aim at reducing such problems wherever they may occur.

Enrolment is limited to 80, and priority will be given to applicants in public administration, industry, medicine, nursing, social work, education, the law and the clergy.

Inquiries should be addressed to:

Summer Course Director,
Addiction Research Foundation,
344 Bloor Street West,
Toronto 179,
Ontario.

A Footnote on Barn-Raisings

In the last issue of *Addictions*, we reprinted an article by Margaret K. Zieman describing the drinking customs of pioneer Ontario. In the course of the article, Mrs. Zieman remarked: "Often such work as barn raising was so poorly done by highly intoxicated workers that the building had to be re-erected by paid labor. Serious accidents were common."

Shortly after publication of the article, Mrs. Zieman received a letter from Dr. H. T. Ewart, Medical Superintendent of the Hamilton Health Association. The letter reads, in part:

"You mention barn-raising, and it reminded me of a story of my great-grandfather, who was a temperance promoter north of Toronto many years ago. The story is that the neighbors came to assist in raising a barn. Since he believed in temperance, he had no liquor at the barn-raising, but brought it out after the building was up. The neighbors consumed the liquor in a hurry and decided that the barn had not been properly built without liquor; so they proceeded to take it down and put it back up again. I can only assume that the barn stood for some years after, as I know nothing more of the story."

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Drugs in Modern Sports

By Andrew I. Malcolm

Every aspect of our culture today is being examined, criticized, and subjected to change. It is as though a thousand years of evolution are now expected to occur in the course of half a lifetime, and any advance more leisurely than this engenders our lashing impatience.

Sports, no less than any other area of human activity, has engaged in the headlong rush into modernity. Sports has become cunning and sophisticated, and it has participated in the universal trend towards specialization. Two quite distinct groups of people have been identified, and their roles have been defined with increasing certainty.

Though it is true that there have always been spectators and players wherever games have been played, we must recognize that today the roles of these two groups of specialists are far more rigidly defined than they have ever been before.

Dr. Malcolm is a psychiatrist on the staff of the Addiction Research Foundation in Toronto. This article is edited from a paper entitled "Two Trends in Modern Sports," which Dr. Malcolm delivered to a Consultation on Sport held under the auspices of the YMCA and YMHA at Cedar Glen, Ontario, in November, 1969. The paper later appeared in the *Journal of the Canadian Association for Health, Physical Education and Recreation*, Vol. 36, No. 3, Jan.-Feb., 1970.

Today we have passive watchers and active gladiators, and both groups know precisely what they must do. The watchers must exhort the gladiators to exceed the very limits of physiology. The gladiators must oblige or be ignominiously discharged and reduced to the status of passive watchers. There is no place for human frailty, spontaneity, or joy. Sports has become, in our time, a deadly serious business.

Now perhaps all this is an absurd and misleading exaggeration. Perhaps it is the sort of ignorant oversimplification that one would expect from a person who has not himself participated in sports for many years and who, in fact, is not even a very learned or impassioned watcher. Under these circumstances I will have to construct my argument with care.

"The name of the game is Win"

First of all, then, we must agree that the two groups of specialists I have identified do indeed exist today. This certainly seems to be the case at the level of professional athletics at any rate; and there is much evidence to suggest that in the colleges and high schools a similar development has occurred. Moreover it must be granted that a primary object of the game is to win. And winning depends on the nicest integration of skill, physical fitness, good fortune, courage, and an intense desire to excel.

Now if all this is true, then it must follow that any tendency that would influence in any way these several variables would be enthusiastically adopted by the players and encouraged by the watchers. Thus over the past few decades an immense amount of knowledge has been gained in such diverse areas as recruitment, role assignment, strategy, nutrition and physical conditioning. Graphs that illustrate the records of succeeding Olympic Games are altogether astonishing. In a number of events the women, who have proceeded along a curve identical to that of the men, have already passed the best achievements of the men of forty years ago.

It must be that sports has been persistently receptive to the

knowledge that has been gained in many other fields. Sports has not been an isolated element in our culture. Rather, it has been an integral part of it in the sense that it has influenced the rest of the culture and has in turn been influenced.

We have lived for some time now in a culture that has been relentlessly scientific. Though there have been extraordinary advances in a thousand directions, no advance has been more successful than that of chemistry. The athletes have not been receptive to every other source of knowledge while steadfastly refusing to be influenced by the chemists. On the contrary, they have been fascinated and very much assisted; and, presumably, they have been grateful.

There has been very little resistance to the introduction of drugs to athletics. After all, in our chemophilic society the easy use of drugs is condoned, encouraged, and imperfectly controlled. And the athletes and coaches live in the same society as do the people who consume both athletes and drugs. It follows from this that if pains, both mental and physical, are freely treated outside the stadium then this same therapeutic attitude must prevail within. Consequently, athletics has very much participated in the general trend towards the increasing reliance on drugs in the performance of its work.

Kinds of drugs used

Three groups of drugs may be considered in this regard. These are the restorative drugs, the body-builders, and the stimulants. The restorative drugs are used primarily to treat medical or psychological conditions so that the athlete may be able to compete unhindered by bruises or anxiety. Thus, athletes may be inclined to use the tranquilizers, the sedatives and the muscle relaxants as uncritically as anyone in the general population.

Similarly, the use of such local anesthetics as novocaine and ethyl chloride and any of the systemic pain killers seems unexceptionable. By very logical extension, it is quite

easy to conclude that such anti-inflammants as phenylbutazone and cortisone should reasonably be used. And having accepted these drugs, it is not very difficult to accept the use of what have been called the anabolic steroids. It is all a very insidious progression that eventuates in a situation that challenges the basic ethics of sports.

Steroids build muscles

The anabolic steroids are hormones that are derived from various plant and animal sources. Androgen, the male hormone, is an anabolic steroid. Now when an athlete, male or female, takes such a drug as Danabol, Durabolin or Nilevar there will follow an accentuation of male secondary sexual characteristics. Thus the voice will deepen, the beard will grow, and the muscles will develop in a typically masculine fashion. The assimilation of protein is facilitated, and thus there is increased muscle mass and body weight. It is by no means established that these anabolic steroids actually improve performance, because muscle mass does not necessarily correlate with strength. Nevertheless, a large number of athletes have apparently concluded that the mere possibility of such improvement justifies the risk and inconvenience of taking these drugs.

The body-building drugs occupy an intermediate point between aspirin and meprobamate on the one hand and the stimulant drugs on the other. With all three groups, of course, the goal is the production of a more efficient competitive instrument. The athlete may be restored to good health with the analgesics, and no one will complain. It is medical and therefore sanctioned by society. He may be given greater power through the use of the male hormones, and again no one will complain. It is a rational application of modern technology, and every athlete, presumably, longs to be a supermale. He may be exhilarated and given greater endurance by the stimulants, and again, it would seem that hardly anyone complains.

This process, if projected into the future, will finally be very injurious to sports; therefore a re-examination of the matter is very much in order. The question is whether the drugs do improve performance, whether such improvement justifies the risk, and whether the very creation of drug-assisted athletes enhances the value and prestige of the sporting arts.

Of the many studies designed to measure the actual effect on physical performance of the amphetamines, the most convincing have been done in the area of sports. Smith and Beecher carried out a series of studies on the effects of drugs on athletic performance. In one of these studies they observed 15 college swimmers, in mid-season condition, swim 360 time trials after receiving 100 mg. of secobarbital, or 14 mg. of amphetamine, or a placebo. After each trial, the swimmer estimated his time and the quality of his performance.

The barbiturate significantly impaired performance and caused the swimmer to judge his performance as excellent when in fact it was unusually bad. The amphetamine significantly improved performance and had no conclusive effect on judgement. The difference between the amphetamine and the placebo in terms of performance was small — a mean of 1.16 per cent — but it must be noted that athletes commonly train for months to gain just such small improvements.

Amphetamines improve performance

In another study, nine track men ran various distances in competitive groups of three. Eight out of the nine ran faster with the amphetamine than with the placebo. The most remarkable improvement with the drug occurred in the case of shot-putters. The mean distance was improved by 4 per cent — a strikingly large increment.

In studies on motor co-ordination and control, caffeine had little effect on reaction time but the amphetamines de-

finitely lowered it, especially in fatigued subjects. Caffeine had no effect on co-ordination, but amphetamine improved this factor as well. Caffeine impaired hand steadiness, whereas amphetamine improved it. In fact, in every test from running the mile to passively monitoring a screen, amphetamine improved performance over the placebo, caffeine had little effect, and the barbiturates and alcohol diminished the quality of the performance.

Not a placebo effect

Nor can it be held that such improvement is caused by the mere inducement of lighter spirits and therefore more favorable attitudes towards the work. It is much more likely that the stimulants caused both attitude changes and performance changes, and that these factors are at least initially independent of one another. Nor can it even be said that only performances degraded by fatigue can be improved by the stimulants. Athletes in conditions of rest exceed the best efforts that they can make on other occasions on placebos. Moreover, athletes engaged in such tests of static strength as weight lifting and operating grip measuring dynamometers also show definite improvement in performance.

Of course there are at least a few studies that report no change in athletic performance. Karpovich, for example, gave 20 mg. of amphetamine to 54 male athletes either one-half hour or one hour before the test. He found no significant improvement in operating treadmills to exhaustion, or in track events or swimming. It may be of some importance that this investigator ran his tests well before the known peak effects of the drug might be expected. Moreover, he used decidedly lower doses than were used in the other studies.

Significant improvement

The consensus, then, is that sedatives diminish performance and the stimulants — especially the amphetamines — improve it. The improvement, it is true, is very slight; but it is

significant all the same. And today the tense and serious state of athletics is such that any slight advantage is highly valued.

It is a very interesting thing that it is horse-racing that has been generally awarded the reputation as the one sport in which illegal doping occurs. The reason for this is curious in the extreme: in the United States, horse-racing is the only sport in which there are written regulations controlling the use of drugs.

Dancer's Image was involved in a great scandal after winning the Kentucky Derby because phenylbutazone was found in a urine sample. No professionals playing football, basketball, hockey or baseball were similarly examined in 1968. These sports, it could be correctly assumed, could not be charged with such outrageous illegalities as had occurred in Louisville. Yet phenylbutazone was widely used by men playing all of these sports in 1968. The National and American Baseball Leagues have no rules regarding the use of drugs. The professional football leagues, the American Basketball Association and the National Hockey League have no written rules relating to the use of drugs.

Bicycle racing bans drugs

It is of further interest that international bicycle racing has achieved an especially bad reputation for drug use. The European cyclists, it would seem, rely heavily on the use of stimulants. Again, the real reason why cycling has this reputation is because it is one of the few sports that specifically bans the use of drugs. The International Olympics Committee, of course, has made every effort to control the use of drugs. The committee specifically bans amphetamines, cocaine, the opiates, hashish, the more potent analgesics, and the excessive use of alcohol.

From time to time, amateur sports organizations in Canada and in the United States express some concern about the use of drugs among young athletes. They publicly deplore the

state of affairs that obtains in professional athletics, and they threaten to discipline any of their own coaches and athletes who are found to be using, supplying, or even advocating the use of drugs. Yet these very governing bodies are, at least to some extent, responsible for the problem. The spirit of competition is no doubt crucial in sports; but today this spirit has become very intense, and the element of enjoyment has been virtually excluded in the process. The athlete who establishes a record or wins a race is honored out of all proportion to the significance of his achievement, and in this way the end has insidiously come to be justified by the means.

“Win at all costs”

In sports, it would seem, anything that will increase endurance or improve the excellence of the performance is readily accepted. The apparently remote consequences of drug use seem to be outweighed in importance by the immediate and entirely measurable advantages.

Thus we now have our gladiators; and these remarkable people are technical and physical specialists. They cannot do many things, perhaps, but they can do at least one thing more efficiently than anyone else. It may even be that the emergence of the gladiator is a benign and agreeable characteristic of our time. The watchers would certainly agree with this. The real significance of the matter is that the gladiatorial impulse has not been confined to the relatively small number of professionals. Today we may observe this phenomenon in progressively more minor and juvenile fields. And to whatever level it permeates we see a concomitant interest in the restorative, body-building, and stimulant drugs.

Two questions

Two questions, then, are worthy of our attention. Should the gladiatorial impulse be allowed to invade and establish its supremacy over amateur and especially juvenile athletics?

And, finally, should we be pleased and complacent on observing that sports has advanced into the modern world and has become more breathtaking — more downright entertaining — through the use of a dazzling array of chemicals?

L'auteur, psychiatre auprès de l'Addiction Research Foundation à Toronto, pense que l'augmentation du dopage sportif crée une situation qui met en question le fondement même du code d'éthique des sports. Chez les athlètes, les drogues sont employées pour atténuer la douleur, pour augmenter les performances et pour améliorer l'état physique. L'auteur se demande si les drogues augmentent effectivement les performances, si ceci justifie les risques découlant du dopage sportif, et si la formation athlétique soutenue par le dopage ne porte pas atteinte au prestige même que l'on attache aux sports. Il remarque que l'idée de gagner par n'importe quel moyen se répand de plus en plus, comme se répand d'ailleurs l'usage des drogues dans les sports amateurs et juvéniles.

Preliminary Brief To the Commission of Inquiry into the Non-Medical Use of Drugs

**From the Research Division of the
Addiction Research Foundation of Ontario**

I. Introduction

1. Purpose of This Brief

The present Commission of Inquiry into the Non-Medical Use of Drugs in Canada presumably has two objectives: to gather and assess information on the patterns of non-medical drug use in various segments of Canadian society and, on the basis of this information, to recommend to the Government the most appropriate actions to deal with problems resulting from non-medical drug use.

The Minister of National Health and Welfare indicated that the use of drugs by youth was of particular concern, but he also stipulated that the inquiry should extend to all aspects of non-medical drug use. Many of the briefs submitted to the Commission so far, and much of the evidence presented at the hearings of the Commission, have been devoted primarily to the question of the legal status of marihuana. We believe, for reasons which will be presented later in this brief, that to focus attention on this question without reference to the whole pattern of drug use in Canada is a misleading if not pointless exercise. The present brief, therefore, is an attempt to place in scientific and social context the broad questions of

This brief was presented to the LeDain Commission at Ottawa, Dec. 12, 1969, by the following officials of the Addiction Research Foundation: H. David Archibald, Executive Director; Robert E. Popham, Head of the Research Division; and Harold Kalant, Associate Research Director (Biological Studies). For this reprinting, the list of references — which ran to 75 items — has been omitted.

drug use, rather than the merits or dangers of any one drug. At this stage of its task, the Commission is presumably attempting to reach preliminary answers to these broad questions, and to identify areas in which valid evidence is scant or lacking. Since it has another year and a half in which to consider specific recommendations to the Government, we have not included in this brief our own views on changes in legislation, provision of treatment services, or educational and public health measures. These will be covered in a later brief.

2. Role of Governments as Protectors of Society

Implicit in the establishment of the Commission is the increasing role of government in what it conceives to be the task of protecting society. Legislation governing the sale and use of pharmacological agents of many kinds, anti-pollution laws, the Canada Pension Plan and the recent medicare legislation, are all examples of government efforts to protect the citizens of the country against illness, accident, ignorance or improvidence. This role is frequently a controversial one, because it raises the issue of the relative merits of government intervention and individual freedom, and the conflict is frequently difficult to resolve.

This is particularly evident in the case of regulation of non-medical use of drugs. At one extreme it is obviously desirable to prevent the sale of deadly poisons, such as cyanide, to children. The hazards of unrestricted sale are obvious and the benefits virtually nil. In contrast, the widespread voluntary use of substances which alter mood or perception implies that the users derive some pleasure or perceived benefit from the use of these substances, and this must be taken into account in assessing the merit of governmental controls.

3. Components of the Process of Decision

The deliberations of the Commission, and subsequently

of the Government, inevitably involve two steps or processes. The first is a relatively objective one, consisting of an attempt to gather all available information about the effects and consequences of the use of different psychoactive agents, by different segments of the population. Those effects which are potentially pleasurable or beneficial, as well as those which are potentially dangerous, should be considered. As the Commission no doubt has learned already from its inquiries, the degree of completeness of available knowledge differs greatly from one drug to another. A particularly important aspect of its inquiries must necessarily be an attempt to distinguish between accurate and reliable data, and hearsay evidence or conclusions based on unsound investigations. Many of the apparent contradictions between the views of reputable authorities are due to a failure to examine critically the evidence on which conclusions are based.

The second step is political rather than scientific, and is based on ethical or value judgments with respect to categorization of the objectively determined consequences of drug use and the relative weights to be given them, as well as considerations of feasibility or social acceptance of control measures which might be proposed.

4. Role of Research in Decision-Making

Increasingly in recent times, many governments have indicated a desire to base decisions of this type on objective evidence. One frequently hears the statement that certain laws or regulations cannot be changed yet because "much more research is needed." We believe that in part this is a valid assertion, inasmuch as any decision stands a better chance of being reasonable if it is based on more complete and more accurate information. However, after all possible information has been acquired and verified scientifically, the final steps in the formulation of legislation or governmental policy will be based upon value

judgments. Even the classification of the effects of drug use as "beneficial" or "adverse" is a process of evaluation with respect to subjective standards. In this brief, we propose to illustrate the roles and limitations of both the objective and subjective processes in relation to governmental control of drug use. For this purpose we have deliberately classified drug effects as either beneficial or harmful in accordance with our best estimate of what the majority view would be.

II. Beneficial Effects of Drug Use

1. Facilitation of Social Interaction

One of the most widely recognized and accepted beneficial functions of mood-modifying drugs is the facilitation of social interaction. This function is served in part by the *symbolic value* of the use of alcohol and other drugs. For example, the use of alcoholic beverages in drinking toasts, in religious ritual, to establish friendship or equivalence of status, or to seal a bargain are symbolic functions related to the traditional analogy between alcohol and blood or vital principle. At a more general level, the use of alcohol, kava, betel and many other drugs symbolizes one's group identification. The use of marihuana by many young people in North American society appears to be motivated, at least in part, by a desire to demonstrate that the user is in sympathy with the "hip culture" as opposed to the society of "squares."

However, it is also clear that this symbolic value of a drug is partly dependent upon its *pharmacological actions*, because the drugs which are used as social facilitators are generally the milder intoxicants, such as alcohol, marihuana, betel, kola, coca, khat and opium (smoked, as opposed to morphine or heroin which are injected). These are most commonly used to produce mild euphoria and some degree of emotional disinhibition. The feelings of

joviality, conviviality and ease of communication undoubtedly reinforce the preference for these drugs in a social context.

It should be noted that the potency of a drug, and the manner of its use, are two distinct matters which are sometimes confused. A potent drug may be used to produce mild intoxication if only a small dose is employed. Conversely, the drugs used in moderate doses as social facilitators will, in high doses, cause stupor, inertia, hallucinations, or other effects which impair social contact. It is easier to produce such effects rapidly with potent drugs (such as whisky and hashish) than with less potent forms (such as beer and marihuana). Therefore potent preparations are usually favored by regular heavy users, especially if they have acquired increased tolerance for the effects of the drug. However, the critical factor is the total dose of active ingredient taken. Therefore it is of little practical value to say, for example, that marihuana is a milder intoxicant than alcohol without reference to the doses used and the effects measured.

2. Enhancement of Sensual Pleasure

Another type of pleasurable or beneficial effect is the enhancement of gustatory and other sensory experience. The use of wine with meals, or the drinking of weak solutions of cannabis in the form of bhang are commonly cited examples. Marihuana and LSD are reported to enhance the pleasure obtained from listening to music, or from looking at beautiful scenery or works of art. They have been reported to increase the sensual pleasure derived from sexual activity, and one of the motives for the intravenous use of large doses of amphetamines is to prolong sexual activity before the attainment of orgasm.

3. Mystical Experience and Self-Understanding

Another function of certain drugs, which is held to be beneficial by some users, is the facilitation of mystical

experiences. In this connection the drug may be incorporated into an organized religion, as peyote is in the Native American Church or it may be part of a less formalized individual exploratory activity aimed at self-understanding, such as that described by Huxley, William James and others. LSD, mescaline and other agents have been used. There is no doubt that such experiences may be attained by other means, and some former advocates of the use of LSD for this purpose now prefer the use of non-drug methods.

4. Exploration and Experiment

The use of agents which modify mood and perception may be part of a purely exploratory activity without religious overtones. It may be one among many methods of attempting to diversify one's range of intellectual and esthetic experiences and knowledge. Such attempts are perhaps most characteristic of the adolescent. Some users claim that hallucinogenic drugs — LSD, for example — increase artistic creativity. This has not been proved by any comparison of the long-term artistic productivity of users and non-users of drugs. Various studies suggest that it is only the subjective satisfaction of the artist, rather than the artistic value of his creation as assessed by others, which is enhanced.

5. Self-Medication

Perhaps one of the most important "beneficial" functions of regular heavy use of drugs is that which may be designated self-medication. In some instances a drug is consciously and deliberately taken for specific therapeutic reasons, even though not on medical prescription. Thus, alcohol, sedatives and tranquillizers are sometimes used to alleviate tension or anxiety connected with specific and recognized situations. Coca leaves are chewed by the Indians of Bolivia and Peru to ease hunger pangs and enhance performance or endurance. The use of ampheta-

mines for the same purpose has been socially sanctioned under certain conditions, e.g., by air crews on long missions during the war, and socially condemned in other instances, as by students wishing to stay awake in order to study for examinations.

However, probably most drug use for purposes which we may designate as self-medication is less clearly recognized as such by the users. The purpose is to change one's prevailing emotional state from depression, anxiety, apathy, over-aggressiveness or other "emotional un-ease" to a sense of well-being. This type of drug use is probably the most subject to debate respecting its classification as beneficial or detrimental. To make such a judgment, one must ask what alternatives to this type of self-medication are presently available. Is drug-taking, at least in some cases, less harmful than the alternative forms of behavior? If the user consulted a physician or psychiatrist because of his discomfort, what is the likelihood that he would be given a prescription for a similar drug to be used for a similar purpose? It is probable that under medical supervision the drug use would be better directed, the dosage better controlled, and the chances of suicide or psychotic reaction smaller; but the questions raised above still merit consideration.

III. Harmful Consequences of Drug Use

1. Toxicity and Organic Damage

The most obvious and uncontroversial harmful effects of drug use are those which give rise to fatalities because of acute drug toxicity. Accidental death or suicide from overdose of barbiturates or alcohol, or cerebral hemorrhage or cardiovascular collapse because of the excessive sympathomimetic activity of a large dose of amphetamine, will probably be accepted without argument as examples of harmful effects. Organic damage which is clearly proved

to be the result of chronic use of drugs is also likely to be accepted without controversy as a harmful effect. A large body of epidemiological, clinical and experimental evidence leaves little doubt of the causal role of the heavy use of *alcohol* in the production of cirrhosis of the liver, cardiomyopathy, Wernicke's syndrome, peripheral neuritis, and other organic lesions caused either directly by alcohol or indirectly because of nutritional deficiency or injury.

The studies on heavy use of *cannabis* are not nearly as complete or thorough, but there is general agreement that the heavy user is neglectful of personal hygiene, pays little attention to his diet and therefore tends to be undernourished and prone to infections. In addition, the study by the Chopras in India showed that those who smoked cannabis preparations most heavily suffered a greatly increased incidence of chronic lung disease, probably because of the strongly irritant properties of the smoke, and the special technique of deep inhalation and prolonged retention of the smoke in the lungs. It seems a reasonable guess that when sufficiently long observation of a large enough number of users is carried out, with proper use of modern diagnostic facilities, prolonged heavy smoking of cannabis will be found to generate the same types of pulmonary and cardiovascular disability, including perhaps lung cancer, as those attributed to the heavy smoking of tobacco.*

Numerous case reports indicate that chronic use of large doses of *amphetamines* also gives rise to malnutrition, and reduced resistance to infectious diseases. This is hardly surprising, in view of the known effect of amphetamines in inhibiting the appetite. More recent observations in this country and elsewhere, since the advent of intravenous use of large doses of amphetamine, indicate that serum hepa-

* See note, p. 29.

titis is an important hazard arising from the use of unsterile needles and syringes.

Within the past three years, a number of reports have indicated the possibility of chromosomal damage as a result of the use of LSD. This evidence is by no means conclusive; and it remains to be established whether the drug itself is responsible for chromosomal anomalies in the users, how frequent this complication may be, whether or not it is transmitted to the offspring, and what the possible effects are on the health of the users and their children.

In general, it is safe to say of virtually any drug that the heavier its use the greater is the risk of either direct or indirect physical damage. Any drug which renders the user relatively oblivious to hygiene and personal needs for an extended portion of his waking hours is likely to result in some deterioration of his health.

2. Psychiatric Damage

Psychiatric ill-effects of chronic drug use are rather more difficult to identify with certainty. Organic psychoses have long been recognized in association with chronic heavy use of *alcohol* and *barbiturates*. Accompanying pathological findings include patchy atrophy of the cerebral cortex. The etiological mechanisms are not fully known, but it seems probable that a variety of factors are involved, including nutritional deficiency, head injuries, and periods of partial anoxia associated with profound intoxication.

Large doses of *amphetamine*, *LSD*, *hashish*, and the newer *synthetic hallucinogens* such as STP (DOM) and other drugs, can produce acute disturbances of perception and emotional response which are part of their so-called "hallucinogenic" effect. In addition to this, however, it is now well recognized that chronic use of amphetamines can give rise to a toxic psychosis closely resembling a paranoid schizophrenia, which may outlast the period of drug use by days or weeks. Furthermore, the perceptual

disturbances generated by the use of LSD and similar drugs may, depending on the personality of the user and the setting, give rise to severe anxiety or panic which may in turn precipitate a true psychosis. Such cases receive a good deal of publicity, both in the scientific and lay press, but the true importance of this problem can be estimated only when there are accurate figures available concerning the frequency of incidents and the severity and duration of the problems produced. So far, fully satisfactory data are not available.

The evidence is similarly unreliable with respect to the so-called cannabis psychosis reported in India, Egypt, Morocco, Brazil, and other countries where potent preparations of cannabis have been widely used for long periods of time. The claims and counter-claims are difficult to evaluate, because in general the psychiatric diagnoses were often not made by professionally qualified persons, documentation was poor, and the relation of the cannabis to the psychosis was not examined in critical fashion. In many instances, apparently, any patient admitted to a mental hospital who was known to have used cannabis at all was listed as an instance of cannabis psychosis. However, the experimental portion of the report of the Mayor's Committee on Marihuana* describes at least one case of temporary psychosis arising during the experiment and for which no cause other than the marihuana could be found. The question deserves careful investigation.

3. Intoxication as a Factor in Accidents

Other harmful effects of psychoactive drugs arise from the acute intoxicant effect for which the drug or drugs are used. For example, there is a large body of evidence concerning the role of *alcohol* in the causation of motor vehicle accidents, injuries and suicides. *Barbiturates* are

* Mayor's Committee on Marihuana. *The Marihuana Problem in the City of New York*. Lancaster, Pa.: Jacques Cattell Press, 1944.

similarly involved in many such happenings. There is also a large body of experimental evidence indicating the interaction between tranquillizers, non-barbiturate sedatives, and other substances with sedative action, when taken together with alcohol. A number of studies of motor vehicle accidents indicate that the events themselves are partly attributable directly to the pharmacological action of the drug, and partly to the personality characteristics of the chronic heavy user.

There is some very preliminary evidence to suggest a similar involvement of *amphetamines* and amphetamine users in motor vehicle accidents. This information is enough to warrant further investigation, but not to demonstrate with certainty a specific role of the amphetamines. There is also insufficient information to permit any valid conclusion with respect to the effects of *cannabis* in this respect. One recent paper reported that a moderate social dose of marihuana did not produce any impairment in a simulated motor driving task, while a very heavy dose of alcohol did. However, the comparison was meaningless, because no dose-response studies were done with the two drugs to establish the relative potencies. As might be predicted, this paper has already been cited as proof that marihuana is not impairing and that it is safer than alcohol.

So far, cannabis does not appear to have been involved to any significant extent in the production of automobile accidents, although preliminary data suggest that chronic users commit more violations of traffic regulations and often believe that their driving ability is impaired by marihuana. In any case, three points should be considered in the assessment of evidence on the question. First, many heavy users of marihuana may be members of a subculture which disavows affluence and does not include many automobile drivers. Second, since cannabis or its derivatives

cannot yet be measured in the blood or other body fluids or tissues, it is impossible to prove its presence in people involved in accidents. Third, the drug is illegal, and some users report that they drive particularly carefully to compensate for what they perceive as impairment, perhaps to avoid the added risk of involvement with the police. If the drug were legalized, and its use became much more widespread, its effects on driving might well become of greater significance. Certainly it can be safely asserted *a priori* that if driving occurred under the influence of a large dose of any intoxicating drug, the risk of accident would be significantly increased.

Some deaths are known or are reported to have occurred accidentally as a result of the hallucinatory state induced by the ingestion of LSD. Others have occurred through accidental suffocation by plastic bags used in the practice of solvent sniffing. Like the psychotic episodes, these accidental deaths are dramatic and have received wide publicity, but the reported cases are relatively few in number and there is probably no valid estimate of the total number likely to have occurred.

4. Anti-social Behavior

Another form of harmful effect arising from the state of intoxication itself is the occurrence of various types of anti-social behavior, including crimes and especially crimes of violence. Such behavior is well known in relation to *alcohol*. Recently also there have been reports of crimes of violence committed by users of *amphetamines*, perhaps in relation to paranoid delusions occurring during acute intoxication. The most striking contradiction occurs in relation to the effects of *cannabis* in this connection. Law enforcement officials in North America and elsewhere have long contended, usually without any convincing evidence, that the use of marihuana leads to the commission of such crimes. In contrast, the proponents of its

use argue that the major effect is to induce a state of passivity which is most unlikely to generate crimes of any kind, and especially crimes of violence. Folk lore and hearsay provide such directly contradictory statements as the following: (a) the Egyptians were rumored to have been so easily defeated by the Israelis in 1967 because most of their troops were in a state of passivity due to the use of cannabis; (b) the otherwise non-belligerent Malagasy males fought courageously against the French because their officers supplied them with a cannabis preparation which released aggressive behavior; (c) the Egyptian government has been attempting for years to eradicate the use of cannabis in Egypt because it gives rise to so many crimes of violence.

Such contradictions may arise for various reasons. One is undoubtedly that many statements are made purely on the basis of preconception or bias, without any supporting evidence whatever. Another may be a failure to distinguish between acute and chronic effects of the drug, or to distinguish between causality and coincidence. Crimes committed by users of cannabis are often attributed to the cannabis, without any attempt to analyse the connection between them. This type of reasoning is well illustrated by the frequent assertion that use of marihuana leads to heroin addiction. A recent study of heroin addicts admitted to the United States Public Health Service Narcotic Addiction Hospitals at Lexington and Dallas showed that although the majority of heroin users had used cannabis previously, they did not begin to use heroin until after being sentenced to penitentiary where they became acquainted with heroin users.

Another probable reason for the contradictions between different writers is the failure to consider such factors as the dose of the preparation used, the setting and the pattern of use. While small doses of marihuana are prin-

cipally mildly euphorigenic, large doses are hallucinogenic. The same dose-dependent gradation of effect has been observed with pure synthetic Δ^9 -tetrahydrocannabinol, which is now believed to be the principal psychoactive component of cannabis. It is perhaps worth noting that it is very easy to extract the resin from marihuana so as to produce a concentrated material with the potency of hashish. If marihuana itself becomes readily and cheaply available, it is reasonable to predict that many people will learn how to make the more potent preparations from the weak ones.

IV. Drug Dependence

1. Significance of the Term "Dependence"

Much of the discussion concerning untoward effects of the use of psychoactive drugs centres around the question of drug dependence. In the past there has been a common tendency to regard dependence as a frankly adverse effect, and to consider physical dependence as worse than psychological dependence. We believe that dependence *per se* should not be regarded as an adverse effect. Dependence is merely a descriptive term indicating a need to continue taking drugs because the interruption of drug-taking gives rise to either a non-specific dissatisfaction (psychological dependence) or a more specific set of physiological disturbances (physical dependence). Whether dependence is harmful or not must be assessed on the basis of its consequences.

2. Physical Dependence

Physical dependence is a well known and thoroughly studied phenomenon which arises with continued intake of large doses of alcohol, barbiturates, minor tranquillizers (including meprobamate and chlordiazepoxide) and opiates. All of these substances produce physiological changes which, on interruption of drug use, give rise to

characteristic clinically observable withdrawal syndromes. This type of dependence is acquired and lost much more rapidly than was formerly believed. Experimental evidence shows that increased tolerance to these agents, and physical dependence upon them, can be acquired within days or weeks of continued intake, rather than months or years. The withdrawal syndromes are harmful in two senses: (a) there is acute discomfort, varying in intensity from mild tremors, sleeplessness and autonomic hyperactivity to the full-blown severe picture of convulsions or delirium tremens; (b) in addition, these withdrawal syndromes carry with them a certain risk of mortality, which is highest for the barbiturate withdrawal picture and lowest with the opiates.

However, if the user continues to take the drug on which he is dependent, in doses sufficient to prevent the appearance of withdrawal syndromes, the fact of being physically dependent is not necessarily in itself harmful. For example, people who are physically dependent upon *opiates* can continue to take maintenance doses sufficient to prevent withdrawal symptoms and continue to function normally for many years. This is the basis of the well known substitution therapy with methadone. There is no evidence of damage arising from the continued use of maintenance doses, except for that caused by the complications of undisciplined use of material obtained through illicit channels. For example, many addicts suffer abscesses and other more serious complications of unsterile injection technique, and some have been known to die from overdosage due to unexpected variations in the potency of the illicit preparations taken.

In contrast, physical dependence on *alcohol* obliges the dependent person to take doses which are likely to cause physical damage. Thus, if he uses enough to prevent withdrawal syndromes during the later stages of de-

pendence, his daily intake is then high enough to give rise to metabolic damage in the liver and other tissues.

The question of physical dependence on *amphetamines* is not yet settled. Many observers believe that it does not occur, even though tolerance is known to increase dramatically. However, some recent neurophysiological evidence suggests that there may indeed be some degree of physical dependence, and that the profound depression which often follows the interruption of amphetamine use may be based in part upon this dependence. The question is not entirely academic, because such dependence might underlie the continued use of the drug even when toxic symptoms have already manifested themselves. This would be analogous to the use of alcohol by the alcoholic for preventing withdrawal reactions.

There appears to be no clinically recognized physical dependence produced by the chronic use of *cannabis*. One might expect that if such physical dependence did exist, a characteristic withdrawal reaction would have been recognized in those countries where prolonged use has existed for centuries. However, the question does not appear to have received extensive experimental study. Abrupt discontinuation of intake of pyrahexyl (a potent synthetic analog of Δ^9 -tetrahydrocannabinol), by volunteers who had taken it daily for about a month, was reported to cause a withdrawal syndrome which included restlessness, insomnia, sweating, "hot flashes," loss of appetite and dysphagia. In a similar experiment with marihuana, this syndrome did not appear. As with amphetamines, it is possible that more sensitive and sophisticated physiological techniques might give some indication of physical dependence with marihuana as well. Oswald *et al* have pointed out the probability that as the physiological and biochemical bases of behavior become better understood, it will be increasingly difficult to draw a

meaningful distinction between physical and psychological dependence.*

3. Psychological Dependence

Psychological dependence can occur with any type of drug and with many types of behavior not involving drugs. It is important to reiterate that psychological dependence is merely a descriptive label for a pattern of behavior which can vary from a trivial and inconsequential reliance upon some generally harmless substance or practice, such as one's morning paper or coffee, to an intense need for a drug which dominates virtually the whole pattern of an individual's life. The potential range of intensities from trivial to severe is well illustrated by the different shades of psychological dependence upon *cigarette smoking*.

Studies carried on in this Foundation and elsewhere show that heavy users of various kinds of drug include a high proportion of emotionally vulnerable or ill people with limited resources for coping with problems of interpersonal relations in everyday life. Such people tend to be multiple drug users, and their behavior illustrates well the fruitlessness of legal measures aimed at controlling the use of individual drugs. Failure to recognize the importance of individual vulnerability in relation to drug use may explain, at least partially, the existence of markedly disparate legal sanctions against the trafficking in and possession of drugs which are used in a very similar manner and often by the same people. It is a reasonable speculation that legalization of *marihuana* would not reduce the use of *LSD*, *amphetamine* and other potent drugs, because the emotionally disturbed heavy user may not find marihuana sufficiently effective for his purposes. The Indian Hemp Drug Commission of 1894 pointed out

* Oswald, I., *et al.*, "Addictive Drugs Cause Suppression of Paradoxical Sleep with Withdrawal Rebound." In Steinberg, H., (ed.), *Scientific Basis of Drug Dependence* (London: Churchill, 1969), p. 243.

that even in India, where cannabis had been legally available for a long time, the very heavy users tended to mix it with *datura* and other drugs because they no longer found cannabis preparations alone sufficiently potent.

It is important to note also that social attitudes with respect to a drug play an important role in determining the extent of use and the composition of the using population. In the case of smoking or drinking, a smaller proportion of heavy users are emotionally sick people than is the case with illegal drugs such as LSD and hashish. This is partly because illegality of a drug itself constitutes a selective factor which deters many of the less disturbed people from using it. In addition, the more seriously disturbed people may well prefer more potent drugs (which are generally obtained illegally) to meet their requirements. Therefore the legalization of cannabis would probably increase the total numbers of heavy users by adding a social stimulus to its use; this would have the effect of diluting the present group of heavy users with a new group of less disturbed or vulnerable people.

4. Economic and Social Consequences of Dependence

Psychological dependence on a drug carries with it certain economic and social consequences of the fact that the user devotes a higher proportion of his total activity to the obtainment and use of the drug. A drug which is obtained through illegal channels is generally more expensive than the same drug obtained through licit medical sources. Therefore a user who is dependent upon it and must obtain it illegally must devote a greater proportion of his activity to getting money for the drug, and it is more likely that some of his activities will be criminal. The classic illustration is the criminal involvement of the heroin addict. In addition, if the degree of dependence is such that the user must be under the effect of the drug during a large part of the day, his other activities such as

employment and non-drug recreational activity may suffer.

The likelihood of this obviously varies with the drug in question, the strength of the dependence, and the normal activities of the dependent person. For example, a business man may be slightly under the influence of *alcohol* all of his waking time, and yet continue to work more-or-less effectively, while an airline pilot obviously could not do so. With *LSD*, which induces gross distortions of perception and of related emotional responses, it is obvious that the user could not continue to carry out normal activities at the same time. Low doses of *amphetamine*, as already noted above, enhance performance in various ways while larger doses, particularly at the level of early or established psychotic symptoms, will clearly impair the performance of normal activities.

One consequence of drug dependence which is of particular importance in adolescent users is the question of emotional and intellectual maturation. The process of maturation involves learning how to cope in a realistic way with the challenges and frustrations which one encounters in everyday life. It has been suggested that adolescents who learn to circumvent displeasing situations by the use of drugs will not learn the necessary mental and emotional adaptations which they require for effective interpersonal relations. This seems to be an eminently reasonable suggestion, and if it is correct, the consequences could be among the most detrimental for society if widespread drug use becomes an established pattern of adolescent behavior. However, we are not aware of any actual study in which groups of otherwise comparable drug users and non-users have been observed over a period of several years of transition from adolescence to adulthood.

Finally, it is probably accurate to say that, in general, progressively greater drug intake will also carry with it

progressively greater risk of the ultimate development of physical adverse effects which have already been noted in Section III (1).

V. Evaluation of Beneficial and Harmful Effects

1. Value Judgement in the Classification of Drug Effects

As we have already noted in the introduction, the classification of any drug effect as either "beneficial" or "detrimental" depends on the scale of values of the person doing the classification. A few examples will make this readily apparent. The enhancement of sensual pleasure of sexual activity by *marihuana* or the prolongation of sexual activity by *amphetamine*, are regarded as harmful by those who regard sexual activity, especially extramarital sexual activity, as intrinsically evil. In contrast, the hedonist may well regard the same actions as beneficial. The decrease of tension and disinhibition of emotional expression produced by *alcohol* and by *marihuana* are generally regarded as beneficial if they give rise to social conviviality, but the same actions are regarded as harmful if they release aggressive behavior giving rise to fighting or crime. Yet even this unmasking of aggressive behavior may be considered beneficial where the circumstances require such behavior, as in war.

The apathy and loss of interest in work which have been attributed by some observers to the chronic use of *cannabis* are regarded as harmful in countries such as India or Egypt in which hard work is required for the economic improvement of society. The same effects are considered praiseworthy by dissenting members of our own society who consider that we have become excessively dominated by material ambitions and work routine. One may even speculate that in a future society where automation might conceivably render work a largely unnecessary

activity, the reduction of competitive behavior by drugs could be considered socially beneficial.

2. Epidemiological Studies of Distribution of Drug Use

Even if all observers could agree on a uniform scale of classification of various drug effects as beneficial or harmful, there would remain the problem of estimating the total extent of the good and the harm resulting from the use by society of any particular drug. Despite the very substantial differences in the pattern of *alcohol* use in such countries as Finland, Canada and France, epidemiological studies have shown that the character of distribution of alcohol consumption in all three is quite similar. It is impossible to divide the population into distinct groups of normal and abnormal users. The curve of distribution shows a continuous spread from a very large proportion of very moderate users at one end to a very small proportion of extremely heavy users at the other end. An increase in degree of acceptance of alcohol use, or an increase in its availability by virtue of lower price relative to income, results in a shift of the whole distribution curve towards the heavier consumption end. Thus, anything which increases total use by the population increases also the proportion of heavy users, including the proportion of those who use enough to suffer organic damage.

Unfortunately there is not yet enough valid evidence to establish the pattern of distribution of use of other drugs. However, there is some scattered evidence which suggests that it will prove similar to that for alcohol. For example, it has been estimated that prior to the passage of the Harrison Act in the United States, there were over a million people dependent upon *tincture of opium*. With severe restriction of the sale and prescription of opiates, the number has decreased markedly. Information on *cannabis* is extremely sketchy and inadequate. Although the drug has been legally available in India for many

many years, India does not provide a good example of the consequences of socially accepted use because social and religious disapproval meant that less than 1 per cent of the total population use the drug regularly and far less than 1 per cent can be considered heavy users. In Morocco, however, where for a time the sale of cannabis was not only legal but was carried on by the government-run tobacco monopoly, the distribution of cannabis use in the population appears to have been not unlike that of alcohol use in other countries. There are even reports of extremely heavy and socially deteriorated users of cannabis in the slums of the large cities, comparable to our own skid-row alcoholic population. The survey data on high school drug use in Toronto and London, Ontario — while by no means enough to permit a definitive conclusion — at least suggest that the incidence of heavy use of drugs is correlated with the extent of total use by the group.

All of this evidence points out two things clearly. First, there is a need for sound epidemiological studies of the use of different types of drugs in different populations, including studies in other countries where the use of such drugs as cannabis by a substantial number of persons has been relatively stable for a considerable time. Second, legalization of any drug can be expected to change the pattern of distribution of its use markedly, and therefore to render invalid any estimates of use and of damage based on a study of illicit use in the same society.

3. Relative Weighting of Beneficial and Harmful Effects

If it were possible to gather complete information on all consequences of drug use, to agree upon whether these consequences should be considered beneficial or harmful, and to estimate accurately the full extent of each, there would still remain the final problem of deciding on ethical and political grounds how much harm to accept in return

for how much benefit. The complexity of this problem is illustrated by the fact that governments have on more than one occasion rejected the advice of expert committees entrusted with the assessment of the most accurate scientific information available at the time. This is shown by the attitude of the government of the United States of America with respect to the recommendations of the New York Mayor's Committee on Marihuana, and the more recent reaction of the government of the United Kingdom to the report of the Wooton Committee.*

Since governmental decisions in such matters cannot be based primarily on objectively definable criteria but must take into account subjective value judgements, it is important to recognize what factors determine the relative weightings which are given to the various components of a total picture, regardless of whether these are independently judged to be beneficial or harmful. This question has been analysed in detail by Goode.† It is probably fair to say that in general we prefer that with which we are already familiar. This perhaps explains the tendency of many people, including many law-enforcement authorities, to prefer the harms and disadvantages arising from the use of known substances such as alcohol and barbiturates to those possibly arising from the use of as yet unfamiliar substances, even though no quantitative comparison has yet been made between them.

4. Individual Freedom versus the General Good

When all these problems have been passed or solved, there remain two basically different approaches to the question of governmental control of potentially harmful substances which are at the same time potentially pleasur-

* Report by the Advisory Committee on Drug Dependence. *Cannabis*. London: H.M. Stationery Office, 1968.

† Goode, Erich. "Marijuana and the Politics of Reality." *Journal of Health and Social Behavior*, Vol. 10, No. 2, pp. 83-94, June, 1969.

able or beneficial. The first is to maximize individual freedom, and to direct governmental action towards helping those who fall victim to their own inability to use the substances wisely. The second and opposite approach is to introduce protective legislation restricting the availability and freedom of use of drugs, so as to protect the more vulnerable members of society, even at the price of some limitation of the freedom of action of the less vulnerable members.

There are numerous instances of both types of approach. For example, the most important cause of adult mortality in North America today is cardiovascular disease, including hypertension and atherosclerosis, in which high intake of saturated fats is believed to play an important etiological role. Yet the government has not chosen to set maximum legal limits of fat content of dairy products and other foods, nor to attempt to set legal limits, by rationing or other means, on the maximum caloric intake of any citizen. This would rightly be considered an indefensible and totally impractical interference with individual freedom, even though it might be medically beneficial to a large segment of the population. Similarly, most scientists now accept as valid the epidemiological evidence indicating a causal role of tobacco smoke in the production of cardiovascular and bronchopulmonary disease; yet the government has not attempted to forbid the sale or use of cigarettes. In contrast, the chlorination and fluoridation of public water supplies, obligatory vaccination for international travellers, and regulations concerning the permissible methods of sewage disposal, have all been initiated or controlled by legislative action, even though in many instances substantial portions of the public have been opposed to one or other measure.

Examples of the difficulty in deciding between these approaches with respect to drug control are also available

in other countries. In the Yemen and certain other portions of the Middle East, the use of *khat* is widespread. The regular use of this amphetamine-like drug tends to cause serious malnutrition, a high incidence of tuberculosis due to lowered resistance, impaired economic productivity, and hardship to the families of the users because they spend a large proportion of their meagre total income in the purchase of the drug. Yet the government has not been able to abolish or restrict its use, because in the eyes of the populace the pleasure derived from the taking of *khat* is more important than its harmful effects.

The argument is sometimes advanced that governmental intervention should be restricted to those types of activity in which harm is caused not only to the individual himself but to those around him. Yet it is obvious that this principle is impossible to apply strictly and in practice it is not followed. For example, it is illegal to attempt suicide, even if no one else can be shown to be directly affected. Moreover, the restrictions on speed of driving an automobile on the highway apply equally whether one is driving on a crowded highway or on a completely empty one where no one else could possibly suffer from an accident incurred by the driver.

5. Consequences of Governmental Decision

Both types of decision carry with them obligations and problems which the government will be required to face in dealing with the subject of widespread drug use. If the first approach is followed, there will be an obligation of society to provide help for the increasing numbers of heavy drug users who suffer physical or psychological damage as a consequence of drug use. Depending on the pattern of evolution of urban society, increasing permissiveness, changes in the goals and values of some groups, and greater amounts of leisure time for others, may cause a larger and larger proportion of the population to use

drugs, with a consequent increase in the frequency of heavy use. Serious thought must then be given to the provision of adequate treatment services for those who require them, or to attempts to reform society in ways which will result in less inducement to use drugs excessively.

If the second approach is to be used, it will be incumbent upon the government to devise a method of restricting drug use which is more effective than legal prohibitions have appeared to be up to the present. In China during the 1920's, the banning of opium was relatively successful because an autocratic regime, using drastic punishments, had sufficient power to enforce the ban. If comparably severe measures were required to prevent excessive drug use in contemporary North American society, there would be real difficulty in assessing whether the benefit of such measures outweighed their harm, as judged by the ethical standards of a democracy oriented towards individual freedom.

For example, present legislation provides for criminal convictions for possession of marihuana, or possession of amphetamines for purposes of trafficking (an offence committed mainly by persons who are themselves heavy users of amphetamines). It has already been pointed out that prison sentences for offenders may provide the link with narcotic addiction. Conviction also automatically deprives the offender of certain future opportunities of employment, and of freedom of movement to some countries. No thorough study has been made of the effects of these deprivations upon the later well-being of the affected person, or his subsequent relations to society. Yet these should be known and taken into account, if governmental action is to be based on as complete an evaluation as possible of the beneficial and harmful effects of drug use.

VI. Conclusions

In the ideal case, legislative action concerning non-medical use of drugs is based on two processes. The first is a scientific assessment of all available evidence about the complete range of effects, the extent and patterns of use, and the factors affecting these. The second is a series of value judgements, involving the categorization of drug effects as desirable or undesirable, and assignment of relative importance to them, and the estimation of social and political feasibility of proposed governmental action.

Scientific information is relatively abundant and reliable with respect to certain drugs and some of the questions mentioned, but seriously deficient with respect to others. Pharmacological, behavioral and epidemiological studies are fairly extensive for alcohol, and to a lesser degree for opiates, barbiturates, tranquilizers and amphetamines. Much less is known about cannabis and the various hallucinogens. For example, such fundamental pharmacological information as dose-response curves for the effects of cannabis, LSD and other hallucinogens is extremely scarce, especially with respect to physiological and psychological functions in man. Such practical questions as their effects on the psychomotor skills and motivational factors involved in automobile driving, and the effects of combination of cannabis with alcohol, require much more experimental study. Most of the questions concerning physical, mental and social effects of long-term heavy use of these drugs are still not satisfactorily answered.

Perhaps even more important are the deficiencies in epidemiological, social and anthropological knowledge. Analogy with the example of alcohol suggests that legalization of use of any drug is likely to increase the extent of its use and, *pari passu*, of heavy use. Yet accurate predictions of the size of such increase are virtually impossible, because so little scientific information has been obtained so far of the extent, patterns and distribution of use of drugs which are presently

illegal. Except for psychiatric studies of small groups of heavy users (usually multiple drug users), very little investigation has been possible of the causes or motives of moderate use of cannabis and other drugs by people who are apparently functioning effectively in society.

For these reasons, it is not yet possible to provide the first of the two bases for ideal legislative action concerning the non-medical use of psychotropic drugs. In the absence of reasonably complete information, it is also manifestly impossible to assign subjective values and draw up a balance of total benefit versus total harm resulting from any given pattern of drug use. Therefore any present proposals for major changes in legislation would have to rest heavily on an assessment of current public attitudes and political exigencies. Such action could not be defended on the grounds of scientific evidence, but would in itself offer an opportunity for one of the largest social and medical experiments yet undertaken.

Ce texte est un mémoire préliminaire présenté par le service de recherche de l'Addiction Research Foundation à la Commission d'Enquête sur l'Usage des Drogues à des Fins Non Médicales (la Commission LeDain). Son intention est d'exposer dans un contexte scientifique et social les questions concernant l'usage des drogues dans son ensemble, plutôt que de déterminer les mérites ou les dangers d'une drogue ou d'une autre en particulier. Il traite du rôle qui incombe aux gouvernements en tant que protecteurs de la société, des divers facteurs qui conduisent aux décisions gouvernementales, et du rôle de la recherche scientifique dans l'élaboration de ces décisions. Il passe en revue les effets bénéfiques et les conséquences nuisibles qu'on attribue à l'utilisation des diverses drogues : d'une part, l'amélioration des relations sociales, la stimulation du plaisir sensuel, les sensations mystiques, la compréhension de soi-même, l'autodécouverte et l'expérience qui en résulte, de même que l'autothérapie; d'autre part, l'intoxication marquée, les dommages physiologiques ou physiques, les accidents et le comportement antisocial. Il traite également des effets qui découlent de la toxicomanie en général, de la relation entre la dépendance physique et la dépendance psychologique, ainsi que des conséquences

économiques et sociales de la dépendance aux drogues. Et pour conclure, le document analyse les effets bénéfiques et nocifs de cet usage, le bien-fondé de cette évaluation, les études épidémiologiques sur la propagation de l'usage des drogues, l'estimation relative des bons et des mauvais effets qui en résultent, la question du libre choix individuel en regard au bien commun, et les conséquences possibles des décisions gouvernementales dans ce domaine.

A Note on the Chopras' Study

When the A.R.F. submitted the foregoing brief to the LeDain Commission, some newspapers gave what many A.R.F. staff members believed was undue prominence to the paragraph that cited the Chopras' findings about cannabis use and respiratory diseases: the headline in one major metropolitan daily was "Research group links marijuana to lung cancer." Many of us were disappointed that this paragraph in the brief was spotlighted at the expense of what we believed was much more important material.

However, now that the subject has been raised, it seems worthwhile to examine in greater detail what the Chopras found and what their findings prove. Among many other findings in a very comprehensive study,* the Chopras found that significantly more subjects who habitually smoked ganja and charas suffered from chronic respiratory diseases than did subjects who habitually drank bhang. Specifically, 48 per cent of the ganja and charas users suffered from chronic bronchitis as compared with 6 per cent of the bhang users, and 8.2 per cent of the ganja and charas users suffered from emphysema — a condition that often follows chronic bronchitis — as compared with 2.3 per cent of the bhang users.

* Chopra, R. N., and Chopra, G. S., "The Present Position of Hemp-Drug Addiction in India." Calcutta: *Indian Journal of Medical Research* (Supplementary Series), Memoir No. 31, 1939. The above note is based on the review in Kalant, O. J., *An Interim Guide to the Cannabis (Marihuana) Literature* (Toronto: Addiction Research Foundation Bibliographic Series, No. 2, 1968).

No "control" data — data on the prevalence of these conditions in a comparable population of non-users — were given.

Bhang is made from uncultivated plants and is comparable to low-grade marihuana; it is customarily brewed and drunk like tea. Ganja is made from specially cultivated plants and is comparable to high-grade marihuana; charas is made from the resin extracted from the plants and is known to us as hashish; both ganja and charas are customarily mixed with tobacco and smoked. Nothing was reported about the uniformity of these preparations as they are made and sold, and the relative strength of the preparations was not reported — although it can be stated with some confidence that both charas and ganja are stronger than bhang, and with rather less confidence that charas is generally stronger than ganja: a few samples of marihuana that have been submitted to the A.R.F. for analysis have been very close to hashish in cannabinoid content.

The bhang drinkers tended to be moderate users: the majority (81 per cent) used 45 grains — about 1/10 of an ounce — or less a day. On the other hand, the majority of ganja and charas users (61 per cent) took more than 45 grains a day.

Some observers have expressed regret that the design of the Chopras' study did not control all the variables — which appear to be the strength of the preparation, the amount habitually taken, the route of administration, and the presence or absence of tobacco. If one had only the Chopras' study to go on, there would be no way of telling which of these variables are significant. However, it is now well established that the slow combustion (pyrolysis) of *any* vegetable matter — tobacco, hemp, or autumn leaves — can produce substances that are irritating and potentially carcinogenic when inhaled. Thus it is fairly clear that at least one significant variable in the Chopras' findings is the route of administration, and it is fairly clear that — as is the case with tobacco smok-

ing — there is a degree of heaviness of cannabis smoking that renders the smoker significantly more liable to chronic respiratory diseases than he is in any case from the irritating and carcinogenic substances in the air he breathes.

What all this adds up to is that cannabis is not completely harmless. This fact should not come as a surprise: there is probably no substance that can be taken into the human body — whether it is eaten, drunk, smoked, or injected — that cannot cause some damage if amounts beyond a certain quantity are taken. In the case of cannabis, some observers believe that deterioration of psychological state, with loss of concern for personal well-being, is likely to be a more frequent and more serious complication — probably at dosages lower than the dosages required to produce emphysema.

It is important for cannabis users to be aware that there is a point in the increasing use of cannabis — as there is with alcohol, methamphetamine, and the opiates — at which the user is likely to become increasingly neglectful of his personal hygiene and diet. It is possible to argue that “personal hygiene” and “proper diet” are exclusively middle-class values; but people who neglect these particular values become undernourished and prone to infection, and they often need to be rescued and treated.

In any case, it can hardly be argued that the ability to breathe is an exclusively middle-class value; thus it is important for the cannabis user to know that there is a point in the increasingly heavy *smoking* of cannabis at which he runs the risk of causing serious damage to his respiratory system. Finally, it is important for the concerned citizen to keep in mind, in the context of the controversy over the “legalization” of cannabis, that the chronic heavy smoker of tobacco runs a similar risk of respiratory damage — although he does not run the additional risk of being prosecuted as a criminal.

The Evaluation of Alcoholism Treatment Programs

By Reginald G. Smart

It is obvious that large numbers of alcoholism treatment programs are established, allowed to grow and expand, and often to disappear without anyone finding out whether they create any harm or benefit. In the present world it is far easier to develop and finance treatments than it is to evaluate them. However, more and more emphasis is being placed on rationalizing the operations of tax-supported agencies. Pressure is increasing for public service and community program workers to evaluate their activities. Most of these programs depend heavily on public funds; it is clear from reading budget debates in Parliament and in the Legislature that searching questions are being asked about the value and efficacy of many health and welfare programs. The general level of public understanding is also increasing, and a more sophisticated and better educated electorate will be less and less likely to accept the need for treatment services on faith alone. It is clear to me that the coming few years will see mounting pressures for evaluative research on all aspects of treatment for mental illness. The need is especially great for research on alcoholism. These pressures will be inexorable, and some sort of evaluative research will have to be undertaken by most agencies.

By "evaluative research" I mean the use of scientific methods of collecting and analysing information about the results of a program. When a former patient says that the therapeutic program he was in has "done him a lot of good,"

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the statement may very well be true; but whether we are scientific investigators or friends of the patient, it is reasonable for us to expect some proof. We want to know in what way the patient's behaviour has actually changed as a result of the therapy. We want to know how many patients in this particular program have actually been improved, and in what ways, and to what extent. These questions can sometimes be threatening to both patients and therapists, and the answers can be embarrassing for all concerned — including the investigators; but if we can find out what is good and what is bad about a certain program we can help that program to become more effective by building on its good features and eliminating its less adequate features.

Article asks three questions

In this article I would like to discuss how we can add to our knowledge about the efficacy of various treatment programs. My aims are to ask and partially answer the following questions: (1) Why is there a need for the evaluation of therapies for alcoholics? (2) What are the necessary elements of good evaluation studies? and (3) What are the main obstacles to doing good evaluative research?

Firstly, then, why is there a need for the evaluation of therapies for alcoholics? Alcoholism is an unusual disease, in that there is no preferred treatment for it: there are fads for the use of various techniques — psychoanalysis, AA, group therapy, encounter therapy, LSD, metronidazole, and the like — but there is no generally accepted treatment that gives more than a modicum of success. In 1963, a review by Bacon of the success rates of various alcoholism treatment programs showed that — with “recovery” defined as abstinence for two years — few programs had recovery rates greater than 35 per cent.

In 1942, Voegtlin and Lemere reviewed all the studies between 1909 and 1941 that evaluated any form of treatment for alcoholics. They concluded that there was no evidence

that psychotherapeutic methods were of value in the treatment of alcoholism. In 1967, Hill and Blane published a paper called "Evaluation of Psychotherapy with Alcoholics: A Critical Review." They reached the same conclusion. This suggests that the scientific case for the use of psychotherapy has not improved in 25 years. Insight therapy of various sorts is still the most widely used method of treating alcoholics; and still nobody has proved whether it works or not, or what makes the difference between therapy that works and therapy that does not.

Some therapists claim that any treatment is better than no treatment at all; but actually the spontaneous recovery rates for alcoholics may be substantial. The spontaneous recovery rate may be about 2 per cent per year: this is the proportion of alcoholics who apparently recovered without formal treatment in Frontenac County, Ontario, in the ten years since 1951. Researchers at the A.R.F. conducted surveys of the number of alcoholics in this county in 1951 and 1961. Of the alcoholics they found in the 1951 survey, more than 20 per cent were not found in the 1961 survey (Newman, 1965). The missing 20 per cent had not died or moved away, but neither had they received any formal treatment for their drinking problems.

Controlled studies of psychotherapy

Psychotherapy, then, has not been proved to be an effective form of treatment for alcoholics. In fact, more and more evidence is accumulating that psychotherapy in general may be of doubtful effect in a variety of mental illnesses. In this connection I would like to direct your attention to an excellent paper by Bergin (1966), which reviews all controlled studies of individual psychotherapy — chiefly with schizophrenics and neurotics. These studies show that, on the average, the people who received psychotherapy got no better than the comparable people who did not. However, psychotherapy caused some people to get better and some to get

worse than the comparable people who did not receive therapy. The average amount of change for "treatment" and "control" groups did not differ, but the variability was much greater in the treatment groups.

Why do patients get better?

These studies show that psychotherapy can make at least some people better off than they were before. The point is not that psychotherapy should be given up, as some have suggested; the point is that far greater efforts should be made to find out why some people get better while others do not. It is also clear from Bergin's review that many "control" subjects who do not get clinical treatment do get help from non-professional sources such as friends, clergymen, teachers, and the like. Thus, the supposedly "untreated" groups may be getting just as adequate therapy as those in clinics, and the term "spontaneous remission" may be wholly inappropriate.

Many studies have shown that therapeutic progress varies according to certain characteristics of the therapist. For example, Truax and Carkhuff (1967) studied many hundreds of case records and reported that three qualities in therapists seemed especially significant in determining the outcome of therapy. One of these was the therapist's ability to be warm and positively inclined towards his patients; Truax describes this quality as "non-possessive warmth." Empathy was also important: the more successful therapists displayed accurate empathy or "sensitivity to current feelings and the verbal facility to communicate this understanding in a language attuned to the patient's current being." Truax called the third quality "genuineness" — the therapist's ability to show that he was really interested in and concerned with the patient's welfare and future growth.

A vast amount of research has shown that therapists vary considerably in their ability to put these qualities to work in their therapy. The research also shows that patients who

recover (in terms of many criteria) experience far more of these qualities in their therapists than patients who do not recover.

So far, these qualities have been identified mainly in the treatment of schizophrenics and neurotics — the treatment of alcoholics has not been studied. It would be useful to find out if non-possessive warmth, accurate empathy, and genuineness are also the major variables in the successful treatment of alcoholics. It may be that the alcoholic needs more confrontation than empathy; but at least it would be useful to know. A major problem with voluntary alcoholism programs is the high dropout rate: about 60 per cent of all voluntary patients disappear before the third interview. It would be useful to know whether alcoholics who drop out are experiencing the important therapist qualities or not. The reasons for dropout constitute one of the most important areas for evaluative research.

As I have suggested already, it is almost certainly unnecessary to conduct more studies to find out whether psychotherapy for alcoholics is better than no therapy. What we seem to need most are studies of the ways in which alcoholism therapy is being carried out, the crucial elements in alcoholism therapy, and the ways in which these elements can be strengthened.

The importance of good design

The second question I have set myself in this article is: What are the necessary elements of good evaluation studies? These requirements are rarely understood or adhered to in contemporary evaluative research. In general, it seems clear that the less well designed an evaluation study is, the more favorable its conclusions will be. For example, Foulds found in 1958 that 72 per cent of the research studies of new treatments reported in psychiatric journals from 1951 to 1956 lacked control groups. Of the uncontrolled studies, 83 per cent reported that the treatment they were studying was successful;

of the controlled studies, only 25 per cent reported success.

In 1969, the NIMH Psychopharmacology Research Branch studied reports of the use of antidepressants and found a similar discrepancy: the studies that involved a placebo control group reported far less efficacy than those that did not have controls. These studies suggest that the conditions for favorable judgements by investigators are created to a large extent by the absence of proper research standards.

The reason for control groups

The basic problem in evaluative research is to be sure that we can attribute the desired change to the treatment we are studying. To do this, we must show that the change would not have occurred without the treatment. Accordingly, we must have some sort of control group; ideally, this should be a group getting either no treatment at all or only non-specific, non-professional forms of treatment. If we are looking at the effects of a new therapy, the best control group is probably a group of patients on a waiting list or in some minimal program such as milieu therapy. A less adequate arrangement is to compare several different facilities that use entirely different treatment methods with the same kinds of patients. For example, we could compare the value of individual psychiatric treatment and of conditioning therapy in two separate facilities — provided we had determined that the two patient populations were similar in all the relevant variables.

Random assignment to groups

In order to make treatment and control conditions comparable, patients must be assigned to treatment groups and control groups on a random basis. This is a stumbling-block to many studies: clinicians often become convinced that a particular patient must have a certain form of treatment, or that he could not possibly be assigned to a “no-treatment” group. Evaluative research cannot produce reliable findings

unless it is free from these restrictions. If there is any provable reason for assigning a particular patient to a particular treatment group, then that evaluation study is unnecessary.

It is also important that the same criteria for exclusion from the study be applied to all patients — in treatment groups and in control groups. Studies involving new drugs often exclude patients with heart and liver ailments from the “drug” group, and there is a tendency to put them in the control group. This practice introduces unacceptable biases; if patients with such ailments are excluded from one group, they should be excluded from the other.

A further need is for some reliable and valid ways of measuring the changes that therapy is expected to produce. Before we select a set of measurements, we need to state and define exactly what kinds of behavior the treatment is expected to modify. This is a more difficult task than is sometimes realized, as “improvement” in many therapies is measured by the vaguest sorts of criteria: good economic functioning, emotional stability, good adjustment, and the like. All of these yardsticks have to be expressed clearly in terms of behavior that can be measured accurately. In fact, we know a lot now about the ways in which such criteria as drinking and social stability can be measured in alcoholics.

Measurement “before” and “after”

Another requirement is that the same measurements must be taken before and after treatment. It is often forgotten that to do evaluative research properly one must have a measurement of the “base line” of behavior before therapy. This is why evaluation studies must be planned in advance of the use of a new treatment rather than when it is well under way. The same measurements that were taken before treatment may be taken during or immediately after therapy and must be taken at some time long after therapy. Follow-up is the factor most often omitted in evaluation studies. Follow-up studies are expensive and time-consuming, but they are

essential if we want to find out the long-term value of treatment. In studies of the treatment of alcoholics, the longer the follow-up period, the fewer the treated patients that are found to have recovered. The best interval for follow-up is a year or more after treatment.

The need for planning ahead

Many evaluation studies are established very late in the development of a treatment program; too many are established only when the program is well under way. Hill and Blane found that out of 49 studies they reviewed, only two were prospective or planned in advance. If evaluation is not planned in advance, this means that proper baseline measures cannot be obtained or that they must be limited to information in clinical files. It also means that patients cannot be assigned to treatment groups or to waiting lists or no-treatment control groups. There are, then, the problems of differing levels of motivation and of patient characteristics confounded with the treatment effects.

Another problem is that retrospective studies do not allow the establishment of reliable measuring instruments appropriate to the treatment being evaluated. A last problem is that retrospective studies do not allow any judgement as to whether the changes occurring after treatment would have occurred anyway and, of course, this is exactly what we want to be able to say. The best procedure, then, is to plan the evaluative research when the unit is opened or when some radical change in technique or philosophy is made. We have found that evaluative research at this stage is more easily initiated and more convincing in its findings.

Finally, what are the main obstacles to doing good evaluative research? The problems are substantial, if the research is to be dependable and convincing.

Evaluation studies often do not get started because some program administrators do not welcome any sort of objective evaluation. Many have been socialized to believe that action

is the best policy, that some treatment is better than none, and that public needs must be met. A few may be concerned that research may not be reliable and valid, but most are convinced of the opposite: that research may demonstrate that their treatment has real inadequacies.

One important goal of all agencies and organizations is to perpetuate themselves, and many program administrators spend considerable amounts of time on their own survival and that of their prestige. Some are concerned that evaluative research may reduce their power or prestige.

As Berelson and Steiner have said, most organizations are "prone to equate power with purpose, or even to place power above purpose so that survival of the organization becomes an end in itself. . . . Most organizations would rather adjust than die." In this sort of situation, evaluative research must be presented as an aid to adjustment rather than a possibly fatal blow. It is mainly by utilizing the results of evaluation studies that organizations can develop rationally and in keeping with scientific facts.

Discussion with clinic staff

Another barrier to evaluative research arises out of the fact that most good evaluation studies require some changes in the way in which patients are dealt with: for instance, patients may be interviewed before, during, and after treatment to measure changes in their behavior. Treatment people often object that these changes will disrupt clinic routine and that the patients may become "disorganized." Of course, whether these clinic routines do any good or not is exactly what we do not know in any provable way, so the objection to disrupting them is not rationally grounded. Prior to any evaluation study, full and free discussion has to take place between researchers and clinic staff about the possible disruption of clinic routines.

In some instances, clinicians and administrators may be concerned that a proposed evaluation study may not be good

research. Some may feel that evaluative research is not really scientific and cannot produce reliable and valid results. Researchers must make every effort to meet these objections in advance by discussing the design of the evaluation study with the clinical people involved.

There is no real reason why the administrative and clinical people in an honest treatment program should perceive good evaluative research as threatening. A better way to see it is as part of the cycle of activities that is involved in providing services to people. Ideally, this cycle should include planning, implementation, and evaluation. If the cycle is seen as continuous, then good evaluation studies should lead to better planning and implementation, and thus to providing better services.

References

- Bacon, S. D., "State Programs on Alcoholism: A Critical Review." Fourteenth Annual Meeting, North American Association of Alcoholism Programs, 1968.
- Berelson, B., and Steiner, G., *Human Behavior: An Inventory of Scientific Findings*. New York: Harcourt, Brace and World, 1964.
- Bergin, A. E., "Some Implications of Psychotherapy Research for Therapeutic Practice." *Journal of Abnormal Psychology* 71, 235-246, 1966.
- Foulds, G., "Clinical Research in Psychiatry." *Journal of Mental Science* 104, 259-265, 1958.
- Hill, M., and Blane, H. T., "Evaluation of Psychotherapy with Alcoholics: A Critical Review." *Quarterly Journal of Studies on Alcohol* 28, 76-104, 1967.
- National Institute of Mental Health, "Study of the Effectiveness of Anti-Depressant Drugs." *Psychopharmacology Bulletin*, March, 1969.
- Newman, A., "Alcoholism in Frontenac County." Unpublished Ph.D. thesis, Queen's University, 1965.
- Truax, C. B., and Carkhuff, R. R., *Toward Effective Counselling and Psychotherapy*. Chicago: Aldine Publishing Co., 1967.
- Voegtlin, W. L., and Lemere, F., "The Treatment of Alcohol Addiction: A Review of the Literature." *Quarterly Journal of Studies on Alcohol* 2, 717-803, 1942.

L'auteur est Directeur associé de la recherche, chargé de l'évaluation expérimentale, à l'Addiction Research Foundation. Dans cet article, il répond à trois questions: Pourquoi a-t-on besoin d'évaluer les différentes formes de traitement des alcooliques? Quels sont les éléments nécessaires à des évaluations utiles? Quels sont les principaux obstacles à cette recherche visant à obtenir de bonnes évaluations? Le Dr Smart affirme que seules des évaluations expérimentales bien conçues permettront aux administrateurs de programmes de traitement de déterminer les aspects de leurs programmes qui se révéleraient les plus efficaces. En connaissance de cause, ils peuvent alors travailler à renforcer ces aspects pour développer ainsi une efficacité d'ensemble.

The Disease Concept in 1838

Then, [Mr. Chairman], to what delusion are we to attribute the madness of the Drunkard? You know, Sir, and this numerous audience know, that men of wealth and education, together with men of warm heart and friendly hand in the more humble walks of life, have alike fallen victims to this horrible vice, the consummation of which is loss of reputation, poverty, and death.

It is a disease — for when once artificial stimulants have been called in to raise our drooping spirits and supply the deficiencies of healthful aliment, the demand for them is like the rage of thirst or the ravenous demand of hunger.

It is famine — for the artificial excitement becomes now as essential to strength and cheerfulness as simple nutritious food once was; for nature, taught to require what once she did not need, will now demand gratification with decision as inexorable as death and, to most men, as irresistible.

The denial is a living death — because the head, the heart, the arteries, the veins, every muscle and every nerve, feel exhaustion and that restless, unutterable wretchedness which puts out the light of life, curtains the heavens, and carpets the earth with darkness.

All these varieties of sinking nature call upon the wretched man, with trumpet tongue, to dispel this darkness and to raise the ebbing tide of life by the application of the “drug” which produces these woes and, after a momentary alleviation, will produce them again with deeper terror and more urgent importunity; for the repetition at each time renders the darkness deeper and the torments of self-denial more irresistible and intolerable.

— From the proceedings of the annual meeting of the Chatham, N.B., Temperance Society, as reported in the (Chatham) *Temperance Friend*, Vol. 1, No. 4, April, 1838.

A.I.T. Addictions

✓ SUMMER, 1970

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Alcohol and its Effects

By the Education Division of the
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Despite the current wave of concern over the use of other psychoactive drugs such as marihuana, LSD, and methamphetamine (speed), it is worth keeping in mind that, so far as we know, alcohol is the most widely-used psychoactive drug in our society and the drug that induces harmful dependence in the greatest number of people.

In Ontario, about 80 per cent of the population over the age of 15 drink some alcoholic beverages. There is good evidence that many more young people of high school age use alcohol than use any other drug, with the possible exception of tobacco. Of the people who do drink, about 85 per cent drink no more than an average of three pints of beer or their equivalent a day; these people are probably in no danger of becoming alcoholics as long as they do not increase their alcohol intake. Those who now take more than three drinks a day but are not alcoholics may or may not, as individuals, be in some danger of becoming alcoholics

This article is available as a separate pamphlet, free to residents of Ontario, from the Education Division of the Addiction Research Foundation.

in the next few years: the dividing lines between low-risk and high-risk drinking, and between high-risk drinking and alcoholism, are not clear-cut. However, about 3.5 per cent of the Ontario drinking population, or some 120,000 people, are clearly alcoholics by any definition.

Some Background Information

The alcohol in beverages is ethyl alcohol, also called ethanol. It is formed naturally by allowing certain fruits, vegetables, or grains to ferment, but it can also be produced synthetically. Fermentation can produce a beverage with an alcohol content of up to 14 per cent; higher alcohol contents in some beverages are achieved by distilling or by fortifying (adding pure alcohol).

In Ontario, the alcohol content of beer is 5 per cent by volume, and of distilled spirits 40 per cent. The natural alcohol content of wine ranges from 7 to 14 per cent; the alcohol content of fortified wine ranges from about 16 per cent to about 22 per cent. A pint of beer or an average-size glass of wine contains about the same amount of alcohol as a 1½-ounce shot of distilled spirits.

In a recent survey, Canadians mentioned the following as reasons for using beverage alcohol: to celebrate an important event; to relax, to unwind, to relieve social or physical discomforts, to promote sleep; to quench thirst, to stimulate appetite, as part of a meal; to entertain guests; as a gesture of hospitality; or to make a get-together more enjoyable.

Alcohol as a Food

Alcohol yields about seven calories of energy per gram. The human body can metabolize about 10 grams of alcohol per hour, which is the amount of alcohol in an ounce of whisky. Thus, a heavy drinker can obtain from alcohol about 1,700 calories in 24 hours, or well over half of his caloric needs. This is one reason why heavy drinkers often suffer from loss of appetite. Unfortunately, alcohol contains no

vitamins or other elements necessary to a balanced diet, so that heavy drinkers often suffer from dietary deficiencies. Many researchers are beginning to believe that persons who drink more than six pints of beer or their equivalent in wine or distilled spirits a day are in danger of suffering damage due to dietary deficiencies.

Up to a point, most organic damage is reversible, if the alcohol consumption is halted. However, extremely heavy drinkers are in danger of developing serious complications such as cirrhosis of the liver, which is irreversible and often fatal. It also appears that heavy drinkers may be more likely than other people to develop heart disease and cancer of the upper digestive system or the respiratory system. As compared with an Ontario non-alcoholic, an Ontario alcoholic has a greatly reduced chance of living to the age of 65.

Alcohol as a Medicine

Alcoholic beverages are of no value in the medication of colds, influenza, or any other infections, except in small doses to improve the patient's feeling of well-being. In fact, heavy drinking lowers the body's resistance to acute infections.

Alcohol is not useful in treating circulatory disease. Despite its high caloric content, it is no protection against sustained exposure to cold weather since it dilates the surface blood vessels and thus dissipates body heat. Similarly, the diuretic (urine-stimulating) effect of alcohol makes it a poor thirst-quencher. Because it stimulates the flow of gastric juices, however, alcohol in small quantities is a good appetizer. Large quantities have the opposite effect.

Alcohol as a Sedative

Before the discovery of ether, surgeons sometimes used alcohol as an anesthetic, and for some time afterward it was occasionally used as a pre-operative medication. However, other drugs have since been discovered whose effects are more easily controlled and that have fewer side-effects.

Alcohol as a Drug

Alcohol acts as a depressant on the central nervous system to a degree that depends on the amount taken and on many other factors, of which the chief are probably set (or mood) and setting, body weight, the amount of food in the stomach, the presence of other drugs in the system, and amount of previous experience with alcohol. Because behavioral effects vary greatly from individual to individual, from time to time, and in various cultures, it is impossible to state definitely that a certain response will occur after ingestion of a certain amount of alcohol.

Generally, however, small doses of alcohol reduce inhibition and thus facilitate social interaction. The fact that talk and laughter therefore come more easily may be the cause of the erroneous notion that alcohol is a stimulant. With larger doses, the user becomes euphoric; there is more loss of inhibition, and the user may begin to act in a way that would strike him as silly if he were sober. Attention, concentration and judgement begin to be seriously affected, and there is progressive degradation of task performance. Dizziness and nausea are also experienced by some people. As the dose increases the user's perception of what is going on around him is altered, and he may act very inappropriately as a result. There is also some impairment of such functions as speech and gait, but some people can be very drunk without showing these effects. Finally the subject may fall asleep. Very large doses often cause memory blackouts: a user may not appear to be very drunk, but the next day he cannot remember what happened after a certain point in the evening. Extremely large doses can be fatal; however, a person is likely to pass out before he can drink enough to kill himself.

Small doses of alcohol can increase enjoyment of sexual intercourse by reducing inhibitions; excessive doses can take away the ability to become fully aroused or to reach an

orgasm. In the male, impotence may occur in either of two ways: a man may be impotent on a particular night because of excessive drinking earlier in the evening, or the physical debilitation caused by repeated heavy drinking may make a man impotent for as long as he keeps drinking heavily. Age is also a factor: some authorities on sex believe that excessive drinking is the most common cause of sexual impotence in middle-aged men. Recovered alcoholics of both sexes often report that their desire for and ability to perform the sex act return soon after they stop drinking.

High doses of alcohol are often a factor in accidents, homicides, and suicides. Even relatively small amounts of alcohol can impair the ability to perform tasks such as driving that require all-round alertness. A recent Ontario test showed significant impairment in the driving skill of professional racing drivers at blood alcohol levels above .05 per cent; this is the blood alcohol level that a 160-pound man could reach if he drank a double whisky (three ounces) in a few minutes. Moreover, many researchers now believe that a high proportion of the people involved in traffic accidents, as drivers or as pedestrians, are alcoholics.

Physical Dependence

The development of tolerance in the case of alcohol is mainly the result of the nervous system's attempt to adjust itself in order to counteract the depressant effect of this drug. Tolerance is the reason why people who have had too much to drink in an evening are jittery the following morning: when the alcohol has been fully metabolized, the nervous system is left overactive. The jitteriness is a mild withdrawal symptom. With heavy drinkers, successive drinking bouts have produced higher tolerance; withdrawal symptoms therefore last longer and are more severe. A hangover can be cured by taking more alcohol; the trouble is that many people take more than enough to cure the hangover and thus have a worse hangover the day following. This condition is known

as physical dependence; without medical attention, it generally ends in a much worse withdrawal state later on. In very severe withdrawal states, the victim suffers hallucinations and convulsions. This condition is called *delirium tremens* or the DT's.

Management of Intoxication and Withdrawal

Time is the only cure for alcohol intoxication; the best thing to do, in severe cases, is to sleep it off. Stimulants such as coffee only keep one awake; they do not sober one up. Antihistamines, tranquillizers, or sleeping pills reinforce the effect of alcohol and make one much more intoxicated. The combination of alcohol and antihistamines or tranquillizers can cause extreme intoxication and erratic behavior; the combination of alcohol and sleeping pills can be fatal.

A mild withdrawal state is best managed by living through it, avoiding the "hair of the dog," avoiding bromides and tranquillizers if possible, and also avoiding stimulants such as diet pills, pep pills, tea, or coffee, which will only make the withdrawal state worse. In the hospital, physicians treat severe withdrawal states with tranquillizers or sleeping pills or both, but these are given under supervision and only after the alcohol has left the system. In severe withdrawal states it is important to pay attention to dietary needs that may have been neglected while drinking, and a vitamin supplement may be indicated. Other medical complications of heavy drinking, including dehydration, are best treated by a physician.

Causes and Treatment of Psychic Dependence

The most important factors in alcohol dependence are psychic, not physical. Researchers now understand fairly well what causes physical dependence and how it works, and physicians know how to treat it. However, when a person lives through a terrible hangover, gets back on his feet, and goes out and gets drunk again, he is generally agreed to be in a state of psychic dependence, and there is no consensus

on what this is, how it works, and how it is cured. A recent Ontario study has found that in a significant proportion of cases — slightly more than 20 per cent over 10 years — the alcoholic has apparently been able to cure himself somehow, without resort to any kind of formal therapy. Others have been cured with the aid of individual psychotherapy or group therapy; with persistent clinical contact, about 25 per cent of patients are generally classified as “much improved” in studies of these forms of therapy.

Employed persons and those with families show better recovery rates than the unemployed and unattached. Some industrial alcoholism programs report very high recovery rates — on the order of 60 per cent or better. Some researchers believe that the factors responsible for these high recovery rates may be (1) the fact that employed people have greater social stability, stronger motivation, and more support from people around them than the unemployed, and (2) the combination of frankness, supportiveness, and firmness on the part of supervisors involved in these programs. Of course, there is also the fact that such patients may not have suffered as much physical damage as others.

About all that seems fairly clear is that at some point in the alcoholic's life drinking and its consequences become more painful than not drinking, and he changes his course. In the parlance of Alcoholics Anonymous, reaching this point is called “hitting bottom.” Alcoholics Anonymous has been described as “a fellowship of self-proclaimed alcoholics who derive a sense of common identity, insight and purpose from recognition of their inability to cope singly with their alcoholism.” To our knowledge, there are no well-designed statistical studies of the success of the AA program as compared with other forms of therapy for alcoholism, but from the very beginning of the history of this organization therapists have been impressed by its success with alcoholics whom they had considered hopeless.

Can a Recovered Alcoholic Ever Drink Moderately?

Probably the greatest single cause of "slips" in the life of a recovered alcoholic is the fact that once he starts to feel better he believes that he can control his drinking. Most therapists who have worked with alcoholics hold that a recovered alcoholic can never consistently control his drinking again, and the entire program of Alcoholics Anonymous is based on the alcoholic's acceptance of the idea that his drinking days are behind him. However, there have been a few well-authenticated reports of recovered alcoholics drinking moderately after a few years of total abstinence. Some therapists believe that the only way an alcoholic can ever drink moderately again is if he honestly doesn't care whether he ever has another drink. Until a recovered alcoholic has acquired this frame of mind, he cannot be said to have eliminated all traces of psychic dependence on alcohol.

Alcohol and the Law

The federal and provincial laws relating to the manufacture, possession, and consumption of alcoholic beverages are confusing, and it is only possible here to give a general picture.

Manufacture

It is legal in Canada to make beer or wine in your own home if you get a licence, but it is illegal to serve what you make to anyone outside your immediate family. It is an offence under the Canadian Excise Act to manufacture distilled spirits, be in possession of a still, or be in possession of illegally manufactured distilled spirits.

Possession

It is legal in Ontario to possess liquor only in your own residence or for the purpose of conveying it to your own residence. "Residence" includes a tent, boat, or trailer occupied as a private dwelling, but does not include a self-propelled mobile home. If you buy a bottle at a liquor store,

it is illegal to consume any of it until you get it home; but it is legal to convey a partially-consumed bottle from one of your residences to another: for instance, from your cottage or hotel room to your home. It is illegal to bring your own liquor to a party in someone else's home. There is some doubt whether it is legal to convey a bottle of liquor to a place other than your own residence, even if you intend to give it as a gift. It is illegal to remove liquor from licensed premises.

Consumption

It is illegal in Ontario to serve liquor except in your own residence; thus it is illegal to serve liquor to visitors in business establishments or to serve liquor at office parties without a special permit. It is legal to serve liquor in premises other than your residence if you get a Special Occasion Permit from the Liquor Control Board.

It is illegal for a person under 21 to consume liquor and it is also illegal to supply liquor to any person who is under 21; if a father gives his 20-year-old son a beer in his own home, the son is technically guilty of consuming and the father is technically guilty of supplying.

Drunkenness

It is an offence under the Liquor Control Act of Ontario to be drunk in a public place, and under the Criminal Code of Canada to cause a disturbance in or near a public place by being drunk.

Driving

It is an offence under the Criminal Code of Canada to drive or have care or control of a motor vehicle, whether it is in motion or not, while one's ability to drive is impaired by alcohol or a drug, or while one's blood alcohol level is over .08 per cent. It is also an offence to refuse to give a breath sample for analysis when required to do so by a police officer who has reasonable and probable grounds to believe that one's ability to drive is impaired.

Criminal Responsibility

In Canada, drunkenness is not a complete defence to a criminal charge. The fact of drunkenness is admissible as evidence to show that an accused person was unable to form a criminal intent, but the actual extent to which drunkenness absolves a particular accused person of responsibility for a particular criminal act is a matter for argument in court. Many courts take the view that if the accused was not fully responsible for committing the alleged act he was at least responsible for getting drunk and ought to have known that he was capable of committing a criminal act while drunk.

Bibliography

- Kessel, Neil, and Walton, Henry. *Alcoholism* (Pelican Book No. A774 in the Social Pathology Series). Harmondsworth, Middlesex, England: Penguin Books, 1965.
- Milt, Harry. *Basic Handbook on Alcoholism*. Fair Haven, N.J.: Scientific Aids Publications, 1967.
- Roueché, Berton. *Alcohol* (Black Cat Book No. BA-12). New York: Grove Press, 1962.
- Schmidt, Wolfgang, and de Lint, Jan. "Mortality experiences of male and female alcoholic patients." *Quarterly Journal of Studies on Alcohol*, Vol. 30, No. 1, pp. 112-118 (March, 1969).

L'alcool éthylique est la drogue psychoactive dont l'usage est le plus répandu dans notre société; on l'utilise pour se détendre, pour stimuler l'appétit, comme geste social ou pour fêter un événement important. C'est également la drogue qui crée une dépendance nuisible chez le plus grand nombre de personnes. Bien que les boissons alcooliques aient une teneur élevée en calories, elles ne fournissent pas les autres éléments nécessaires à un régime équilibré. C'est pourquoi les forts buveurs souffrent souvent de perte d'appétit, de carences alimentaires ou de complications plus graves, dont certaines sont irréversibles. L'alcool ne présente guère d'intérêt au point de vue médical.

L'alcool déprime le système nerveux central. Son effet varie selon la dose ingérée, selon la personne qui l'ingère et selon l'ambiance. Habituellement, une petite dose d'alcool réduit les inhibitions. Les doses plus élevées causent de l'euphorie, puis affectent l'attention et le jugement, et entraînent parfois des étourdissements et des nausées. Les doses encore plus élevées affectent la perception, et causent des troubles de la parole et de la démarche; la personne

peut finir par s'endormir. Les doses très élevées peuvent parfois être mortelles. L'ingestion de doses élevées d'alcool est souvent un facteur d'importance dans les accidents, les homicides et les suicides.

L'alcool peut produire une dépendance à la fois psychique et physique. Bon nombre d'alcooliques ont été traités avec succès par la psychothérapie — individuelle ou en groupe — ou par des organismes d'alcooliques réformés comme les Alcooliques anonymes. Les personnes qui ont un emploi et celles qui ont un foyer ont un taux de rétablissement plus élevé que les chômeurs et les personnes seules.

New Textbook on Alcoholism

A new book, *Alcohol and Alcoholism*, published for the Addiction Research Foundation by the University of Toronto Press, contains fifty papers by leading authorities in this field of study. The papers were originally presented at the International Symposium on Alcohol and Alcoholism that was held in Santiago in 1966 as a memorial to the late E. M. Jellinek, who has been described as the "father of the scientific approach to the problems of alcohol." They have been edited by Robert E. Popham, head of the A.R.F.'s research division.

The editor says in his preface that the function of the book is to serve as a supplementary reading text "for use in schools of alcohol studies and in university courses dealing in part with alcohol problems. A few such texts exist but are concerned mainly with social and psychological aspects. Without neglecting these points, the International Symposium stressed the areas of pharmacology, pathology, and psychiatry. Its proceedings are therefore better suited to the needs of those with a prospective medical interest in the field, whether from the standpoint of research, treatment, education, or the development of comprehensive programs embracing all these activities.

"With this educative potential in mind, efforts were made to standardize the presentation of tabular, graphic, and

bibliographic data; to check the accuracy of references and bring them up to date where necessary; and to compile a more than usually comprehensive subject index as well as a separate author listing. . . .

“Contributors were free to report original work if relevant, and many did so. But they were also asked to review the current status of knowledge in their subject areas. Consequently, most papers are suitably general in character and comprise, on the whole, a logical series covering the field within the broad limits previously indicated.”

Society and the Drunk: Three Possible Transactions

(With acknowledgements to Eric Berne and Claude Steiner)

Transaction 1

Society: “You’re a drunk (drunkard, alcoholic).”

Drunk: “Whaddaya *mean*, I’m a drunk (drunkard, alcoholic)? (Etc., etc., etc.)”

Transaction 2(a)

Society: “You’re a drunkard.”

Drunk: “You’re right, I’m a drunkard, so do me something nasty, I deserve it. (Ridicule me, bawl me out, fire me, beat me up, put me in prison.) That’s what you have to do, it says so right here.” (Points to motto on the wall that says: “Evil pursueth sinners.—Prov. 13:21.”)

Transaction 2(b)

Society: “You’re an alcoholic.”

Drunk: “You’re right, I’m an alcoholic, so do me something nice, I’m entitled. (Come and rescue me out of this awful bar, chauffeur me to an AA meeting, give me a free lunch, a free flop, a drink, a pill, cash my cheque, sympathize with my hard-luck story, laugh with me at how funny I am, admire my insight.) That’s what you have to do, it says so

right here.” (Points to motto on the wall that says: “I’m only trying to help you.”)

Transaction 3

Society: “You’re a drunk (drunkard, alcoholic).”

Drunk: “I guess that’s right, I *am* a drunk (drunkard, alcoholic)—so it’s up to me to do something about it.” (Nods ruefully at motto on the wall that says: “When the going gets tough, the tough get going.”)

Society: “Show me you mean business, and I’ll help you all I can.”

(“Society and the Junkie” and “Society and the Speed Freak” offer parallel sets of transactions that differ only in terminology and detail.)

—ALASDAIR MCCRIMMON

The Social Background Of Narcotics Legislation

By Shirley J. Cook

The history of narcotics legislation in Canada since 1908 is characterized by several anomalies that make it an interesting subject for study.

First, there is the paradoxical fact that in a period when the general tendency in criminal law has been towards less severe penalties, a lesser use of imprisonment, and greater safeguards for the civil rights of individuals, the trends in narcotics laws have been in the opposite direction. Here penalties have increased, the number of offences that entail imprisonment have been enlarged, and many of the legal safeguards available in prosecution of other offences have been removed by statute. Even the emergence of the counter-movement based on the premise that addiction should be treated as an illness has not substantially changed this trend.

A second anomaly is that a law originally intended to control groups that engendered prejudice and discrimination — the Chinese immigrants and the marginal whites who associated with them — is today the vehicle for the prosecution of large numbers of young people from middle-class homes. In the 1920s Parliament was horrified to hear about the machinations of the oriental "Drug Ring," which cunningly inveigled young white men — and, worse still, white women — into taking drugs at lavish "snow parties."¹ After

Shirley Cook is a lecturer in sociology at the University of Toronto. This article is edited from a paper Mrs. Cook presented to the annual meeting of the North American Association of Alcoholism Programs in Vancouver in September, 1969. The material was collected as part of a larger project under the direction of P. J. Giffen, chairman of the sociology department at Toronto and a research scientist with the Addiction Research Foundation. The author was assisted in the collection of data by Brent McKeown, Margaret Aboud and William Calder.

the "oriental menace" faded, the "criminal addict" became the villain. The law was intended to suppress addiction in people who were beyond the pale of respectability: thieves, pimps, prostitutes, and other deviants. This same law has come to be used in recent years against high-school and university students, most of whom have never been involved with the courts before.

With the change in the status of the offender, we might have expected less energetic enforcement; but this has not been the case during the last three years.

Finally, the penalties prescribed by statute kept increasing in severity over a period when the use of hard narcotics was apparently decreasing. The number of addicts dropped from an estimated 9,500 in 1923 to 4,000 in 1938 and 3,200 in 1955. During this period, the population of Canada doubled. Canada experienced no upsurge in heroin addiction in the 1950s comparable to that in the United States. Unless marihuana users are counted as "addicts," the number has remained fairly constant over the last several decades.

A search for an explanation of these anomalies has led me to study the social concomitants of the origin and development of Canadian narcotics legislation. This article will describe the pattern of development that has emerged from the large amount of material my fellow workers and I have collected. Unfortunately, some of the more interesting causal sequences that led to various specific changes in the legislation cannot be dealt with in a short article.

The general trends in Canada have resembled those in the United States more than those in Great Britain. Some distinctively Canadian features are related to the fact that the federal government has absolute jurisdiction over criminal legislation. Our narcotics law did not have to be disguised as a tax act, and our provinces do not have their own narcotics laws. Moreover, because the Division of Narcotic Control is directly responsible to a federal cabinet minister, who in turn sits in Parliament, there has been less oppor-

tunity for the Canadian law-enforcement agency to become a pressure group appealing directly to the public and to legislators as the former Federal Bureau of Narcotics used to do in the United States. The propaganda aspects of the enforcement ideology have not been as highly developed in Canada; and the counter-movement, in turn, has found it much easier to get a sympathetic hearing.

The first Canadian law to prohibit opium was not a consequence of public agitation but an indirect result of public hostility towards Chinese immigrants on the West Coast. As a result of anti-Asiatic riots that took place in Vancouver in 1907, the Laurier government sent its Deputy Minister of Labor, William Lyon Mackenzie King, to process claims for compensation. Much to King's surprise, he received two claims from opium manufacturers for losses sustained during the riots; and this prompted him to conduct a private investigation of the opium traffic in British Columbia. He collected a few newspaper clippings, visited some opium dens, and bought some opium over the counter. His conclusions appeared in a document entitled *Report on the Need for the Suppression of Opium in Canada*.

Legislation to prohibit the opium traffic was needed for two reasons, according to King: (1) to assist the government of China to suppress the traffic in that country, and (2) to protect the white population — especially the women and girls. He stated, without any documentation, that "the amount consumed in Canada, if known, would probably appal the ordinary citizen who is inclined to believe that the habit is confined to the Chinese and by them indulged in only to a limited extent."²

King's moral entrepreneurship led to the first two of several acts (and numerous amendments) passed during the next fifty years to control drug abuse in Canada. The act passed in 1908 was intended to suppress the importation, manufacture, and sale of opium for other than medicinal purposes. We get a picture of the amount of time and energy that went

into the development and enforcement of the legislation if we summarize the changes that have taken place in the number of banned substances and of forbidden acts, and the severity of the penalties.

The Opium and Drug Act of 1908 prohibited opium only; over the years, the list of proscribed substances has expanded until it now includes the opiates, cocaine, cannabis, and the synthetic analgesics: the Narcotic Control Act of 1961 lists 89 specific drugs.

By 1929 there were 28 offences in the legislation, including improper packaging, selling or giving drugs to minors, manufacturing without a licence, filling a prescription from an unknown doctor without verification, neglecting or refusing to make the declaration required by druggists and physicians "in the prescribed form," being in possession of an opium pipe or opium lamp without first obtaining a permit, being found without lawful and reasonable excuse in a place in which persons resort for the purpose of smoking opium, and enclosing drugs in a letter. The cultivation of opium and marihuana was added in 1938, possession for the purpose of trafficking in 1954. Only in 1961 was the number of offences reduced to a more manageable seven.

The maximum penalties have also increased. Originally they were imprisonment for three years, or a \$1,000 fine, or both. In 1922, two more penalties were incorporated into the legislation: whipping — at the discretion of the court — for giving drugs to minors, and the mandatory deportation of convicted aliens. The legislative debate in 1922 made it clear that the oriental drug trafficker had emerged as the villain. Two Members of Parliament expressed the hope that deportation of those convicted under the Opium and Narcotic Drug Act would help "to solve the oriental question in this country."³

In 1929 whipping was extended, at the discretion of the court, to any conviction of possession or trafficking. Imprisonment came to be mandatory for the major offences, with a

fine as a possible additional punishment. By 1952 a minimum prison sentence of six months was mandatory for possession, importing, and trafficking. In 1954 a new offence, possession for the purpose of trafficking, was created. The maximum sentence for this offence, as well as for trafficking, was 14 years in 1954. The 1961 act removed most minimum sentences and eliminated whipping; but it increased the maximum penalty for trafficking to life imprisonment and the minimum for importing and exporting to seven years. The latter is the heaviest minimum sentence in Canadian criminal law, except for capital and non-capital murder.

This increase in the number of drug offences and in the severity of sentences would not have been possible without a strong set of justifying beliefs on the part of those who made the law. The statements of those concerned with the early legislation indicate that they started from the premise that human beings are by nature depraved and must be coerced into virtue. More specifically, narcotic use was believed to be highly contagious, very damaging physically, and capable of producing a totally changed personality — the classic “dope fiend.” Under the influence of drugs, otherwise law-abiding citizens became sexually immoral, committed violent crimes, and eventually became raving lunatics. These consequences were thought to be possible as the result of using any of the three major “narcotics”: cocaine, the opiates, and marihuana — which, in discussion of their effects, were indiscriminately lumped together.

Canadian doctors were warned in a 1923 issue of the *Canadian Medical Association Journal* that “the drug addict is not content with destroying himself, but has a fiendish desire to promote this addiction among his friends and associates.”⁴

The most influential advocate of punitive legislation — apart from Mackenzie King and the Vancouver Members of Parliament — was Mrs. Emily F. Murphy, a police magistrate and a Judge of the Juvenile Court in Edmonton. In

1920 she was asked by the editors of *Maclean's* magazine to write a series of articles on the "grave drug menace." Later she expanded her views in a book called *The Black Candle*.⁵ Citing various Canadian and American law-enforcement authorities, Mrs. Murphy unfolded the horror of opium, cocaine, and marihuana in no uncertain terms. Opium smokers were described as "ashy-faced, half-witted droolers" with no more blood in their bodies "than a shrimp."

Under the influence of the drug, the woman loses control of herself; her moral senses are blunted, and she becomes "a victim" in more senses than one.⁶

A picture in the book shows a white woman and a black man lying on a bed, with opium-smoking equipment between them. The caption reads: "When she acquires the habit, she does not know what lies before her; later she does not care."⁷

One chapter of the book is devoted to "marahuana — a new menace." In it we are informed that three of the American states — California, Missouri, and Wyoming — already had legislation against its use. A police official from California is quoted as saying that the addict who uses this narcotic is driven "completely insane," "loses all sense of moral responsibility," and may "indulge in any form of violence to other persons, using the most savage methods of cruelty."⁸

In 1923, a year after the publication of Judge Murphy's book, Indian hemp was added to the schedule of the Opium and Narcotic Drug Act — despite an apparent absence either of users or of public concern.

The set of beliefs outlined above constituted the mythology of addiction for a very long time, and were an important reason for the widespread acceptance of the unusual severity of the legislation. Later on the stereotype of the "criminal addict" emerged, in which the users were thought to be primarily incorrigible criminals.

The uncritical acceptance of these beliefs was partly explained by the fact that most legislators and members of the public had neither first-hand experience nor scientific knowl-

edge of the subject. Also, the concentration of power and expertise in the hands of law-enforcement authorities discouraged — or at least did not stimulate — the emergence of other points of view.

The organization in which power was concentrated was the Opium and Drug Branch (later the Division of Narcotic Control) of the Department of Health, established in 1920 to enforce the narcotics legislation. From the outset, the branch worked closely with the Royal Canadian Mounted Police — the force that did and still does most of the criminal investigation work in relation to narcotics offences. At the same time the branch, being part of a government department, has been able to suggest changes in legislation with reasonable assurance that they would be introduced as government bills; and it has provided much of Canada's representation on international bodies dealing with narcotics control. This unusual concentration of functions, together with the failure of physicians or other professional groups to show any interest in the field until the 1950s, meant that the enforcement ideology unobtrusively dominated policy at all levels.

The consequences of this enforcement monopoly have been along predictable lines. The traditional police interest in severe penalties has been clearly manifested in the legislative trends mentioned earlier. Harsher penalties, by making the offence more "serious," have enhanced the importance of the enforcement job — as well as providing such practical advantages as greater bargaining power in dealing with informers. The enforcement concern with the difficulties of securing evidence and ensuring conviction has been reflected in successive statutory encroachments on traditional legal safeguards.

The right to search without a warrant was introduced in a bill in 1921, and a ban on appeals on matters of fact was introduced in 1922. The Senate turned down each of these clauses once, but relented a year later when the government

made it clear that these changes would not affect ordinary citizens. In the general context of the debate, it is clear that the senators believed these measures would only be used against Chinese drug pedlars.

Beginning in 1911, the burden of proof was placed on the defendant to show that he was legally in possession of opium. After 1921, if narcotics were found in the building or room or vessel belonging to the defendant, he was assumed to be guilty of illegal possession unless he could prove otherwise. An amendment in 1923 put both doctor and patient under the obligation of proving that narcotics were prescribed for medicinal purposes.

The Writ of Assistance, the most controversial of these measures, was introduced in 1929. A Writ of Assistance is a blanket warrant given to an enforcement officer on application to the Exchequer Court. "Once granted the Writ is valid until the person is relieved of his duty to enforce the particular Act under which his Writ was issued."⁹ A Writ of Assistance authorizes the officer named in it, with any persons he may require to assist him, "at any time, to enter any dwelling house and search for narcotics." He and his assistants may "break open any door, window, lock, fastener, floor, wall, ceiling, compartment, plumbing fixture, box, container or any other thing."¹⁰

In 1954 a new offence was created at the request of the police: possession for the purpose of trafficking. The onus was on the Crown to prove that the accused was in possession of an illegal drug, and then the onus was on the accused to prove that he did not have it for the purpose of trafficking. If he could do so, he would be found guilty of simple possession; if he failed to do so, he would be convicted of the offence as charged.

Several appeal-court decisions show that the Canadian judiciary approved of these drastic departures from ordinary judicial practices because the work of detection in drug cases was so difficult and the results of the drug traffic were con-

sidered so disastrous.¹¹ In 1944 the case of *Rex v. Brezack* centred around the legality of an officer's exploring a suspect's mouth with his fingers in a search for prohibited drugs. The judge ruled that "constables should be instructed that there are limits upon right of search, including the search of the person, [but] they are not to be encumbered with technicalities in handling the situation with which they often have to deal in narcotics cases."¹²

These encroachments on judicial safeguards for the defendant lessened in 1961 when the ban on appeals on matters of fact and many of the "onus of proof" clauses were rescinded. The burden of proof is still on the defendant to prove that he was not in possession of a drug for the purpose of trafficking and to show that any exceptions or qualifications in the law operate in his favor. The Writ of Assistance is also still in the law. (All these 1961 items are also present in the Food and Drugs Act, which regulates LSD and other hallucinogens as well as the barbiturates and amphetamines.)

The monopoly of the law-enforcement authorities in the management of the drug problem was maintained partly by default: the medical profession did not assert a claim. Apparently, medical practitioners were willing to let the police have the authority, not only over addiction, but over themselves as well. Seventy-seven physicians were prosecuted under the Opium and Narcotic Drug Act in the years from 1921 to 1925, without any apparent objection on the part of the organized profession. Nor was there opposition to a 1925 amendment that prohibited giving drugs for self-administration to persons suffering only from the consequences of addiction, although this amendment might have been interpreted as an infringement on the right of the medical profession to decide what constitutes proper medical treatment.

This amendment was vigorously enforced by the RCMP, even to the point of sending addict-informers into doctors' offices to try to obtain narcotics — ordinarily by feigning illness.

In the House of Commons the tactics of the police were assailed, but the philosophy underlying them was not. The *Canadian Medical Association Journal* simply warned its readers that a recent case using this sort of evidence had shown that "the stringent provisions of the Canadian law as to giving narcotics to be used by the individual himself, may not be as well known to the profession as they should be."¹³

This apathy on the part of the medical and other helping professions could not last forever. The increasing emphasis on therapy as a means of dealing with personal pathology was bound, eventually, to challenge the enforcement monopoly. The first organized movement to promote this more humanitarian "coercion to virtue" appeared in Vancouver.

The Vancouver Community Chest, a federation of welfare organizations, established a committee to study addiction. In December of 1952, with the support of the British Columbia Medical Association, this committee urged the federal and provincial governments to take four lines of action:

Institute a program of adult and youth education concerning the dangers of narcotic addiction,

Establish an experimental treatment program,

Allow the formation of narcotic clinics where registered users could receive maintenance doses as part of a general rehabilitation program,

Increase the penalties for large-scale traffickers and re-write the law so as to distinguish between these persons and the minor traffickers.¹⁴

The government responded by establishing a Senate committee of inquiry, which held extensive hearings. The police and enforcement officials who testified argued that enforcement pressure on traffickers was not enough: the problem could never be solved without continued "vigorous action against the addicts."¹⁵ The Chief Constable of Vancouver wanted addicts removed to an island colony, in the same fashion as the Japanese Canadians had been forcibly evicted from British Columbia during the Second World War.

The report produced by the Senate committee shows that

the senators were particularly impressed by the argument in favor of strong law-enforcement. They enjoined the Vancouver police to produce "more vigorous effective enforcement of all pertinent laws,"¹⁶ such as those dealing with vagrancy and prostitution, to eliminate the concentration of drug addicts in that city. The drug user was to be treated primarily as a criminal, and only secondarily as an addict.

The problem of the treatment of addiction was also given serious consideration; eleven physicians gave testimony. In its report, the Senate committee urged the provinces to pass legislation to provide for "the committal on a compulsory or voluntary basis of drug addicts to an appropriate treatment centre in much the same manner as is being done for those in need of treatment for a mental condition."¹⁷ The police were still to be the vanguard in the battle against narcotics, with the doctors providing a secondary line of defence.

This solution was given legal sanction in the Narcotic Control Act of 1961. In Part I of this act the penalties were increased, and all offences were to be proceeded against by indictment only. Part II, which still has not been proclaimed, provides that any convicted narcotics offender is entitled to ask for a medical examination to determine if he is a narcotic addict or not. If the examining physician finds that the offender is an addict, then the court shall "sentence him to custody for treatment for an indeterminate period, in lieu of any other sentence that might be imposed for the offence of which he was convicted."¹⁸ From the viewpoint of an addict, such an indeterminate sentence might appear more punitive than a specific time of imprisonment — especially if it means that he must remain under parole supervision for the rest of his life.

It is important, in the long run, that the 1961 act encouraged the medical profession to take responsibility for addiction by removing from the act all references to the licit use of drugs by physicians. Henceforth these would be covered in the regulations — which, the House of Commons

was assured, would allow a doctor to prescribe, administer, or furnish a narcotic to an addict if this was thought to be proper procedure in the professional judgment of the physician.

The road was now open for the addiction organizations in British Columbia and later in Ontario to establish treatment programs for addicts on any basis they chose, including long-term programs of methadone treatment.

In 1965 a special committee of the Canadian Medical Association issued a report that broadly defined what constituted "good medical practice" in the treatment of addiction;¹⁹ the CMA definition was much more permissive than the equivalent American statement.

All of these experimental programs, and the legislation that allowed them to be set up, were designed to deal with heroin addiction. Although marihuana had been on the schedule since 1923, the police assured the Special Senate Committee in 1955 that "marihuana addiction" was no problem in Canada. In 1938 the House of Commons had been told that cultivation of cannabis was being prohibited because, while marihuana was not a new drug, it was a "new menace to the youth of the country."²⁰

However, this new "menace" did not materialize for almost twenty years; when it did, it was in a form that had not been envisaged by those who had put marihuana on the schedule. They had no way of knowing that in the 1960s the use of marihuana would become part of a youthful "experiential subculture" — a way of life that had no respect for the past, that emphasized gratification by experiences in the present, and that had little apparent concern for the future.

The emergence of this subculture, of which drug-taking is one feature, has posed a new dilemma for those responsible for making and enforcing the laws. The main source of the dilemma is the status of the drug users: few of them are from lower-class backgrounds, and many are clearly in the edu-

cational categories from which future leaders are normally recruited. The higher social status of many marihuana users has led to concern over the possibility that subjecting them to the criminal process may alienate them from society — a possibility that apparently did not worry many people when the only drug users subjected to the criminal process were lower-class heroin users. The Minister of National Health and Welfare, John Munro, has warned that for some young people marihuana is becoming “a symbol of persecution of their generation.”²¹

Important attributes that accompany the higher social status of contemporary marihuana users are their articulateness, their money, and their ability to challenge publicly the legislative premise that heroin and marihuana use are essentially similar evils. Mr. Munro has observed that the Canadian and U.S. governments, by employing scare tactics, “have been . . . guilty . . . of the indiscriminate overkill which has been effective only in reducing our own credibility.”²²

The opposition to the application of the criminal process to offenders of this type has been growing among responsible groups outside the experimental subculture. This opposition has been implicit in the tendency of many courts to give suspended sentences to first offenders. It has been explicit in newspaper editorials, and in briefs presented to the federal government by such bodies as the John Howard Society and the Canadian Home and School Association. These groups generally seek some way of avoiding the criminalization of the young without legalizing the use of marihuana. The panacea seized on most optimistically has been a proposed shift of marihuana from the Narcotic Control Act to the Food and Drugs Act, which would mean dealing with it in the same way as LSD. Mr. Munro has said that this change would mean that “persons caught experimenting with it are not automatically saddled with life-long criminal records,”²³ and his belief seems to have been widely shared.

However, the Department of Justice, in a press release

dated August 20th, 1969, pointed out that simply making an offence punishable on summary conviction rather than after indictment did not mean the absence of a criminal record. Although a summary offence does not entail fingerprinting, it is formally a crime if it is a breach of a federal statute. A youngster with a conviction under the Food and Drugs Act would be untruthful if he failed to answer in the affirmative a question about whether he had ever been convicted of a crime — a very important question if he was applying for certain jobs, or for an immigration visa for the United States.

To do away with the criminal stigma, possession of marihuana would have to be either eliminated as an offence entirely, or put under the “quasi-criminal” statutes of the provinces, such as those that regulate the use of alcohol. The recent amendment to the Narcotic Control Act, which allows the Crown the option of prosecuting simple possession offences by summary proceedings, seems to accomplish nothing except to allow the court to fine first offenders. It should be noted that the RCMP, in testimony before the House of Commons Standing Committee on Justice and Legal Affairs, opposed any change in the penalties for possession of marihuana — including a shift to the Food and Drugs Act — mainly on the grounds that marihuana is a stepping stone to heroin.

After a long period during which the police held a monopoly of expertise about the various drugs that are controlled by the narcotics legislation, we are now in an era in which there are three sets of experts: the police, the medical and related professions, and the highly articulate users — each with their own set of beliefs. As this article goes to press, the preliminary report of the LeDain Commission has not yet been tabled in the House of Commons; but, whatever the Commission recommends, it will be making judgements about the relative credibility of these three groups.

In the meantime, the number of substances being used in

the drug subculture increases continuously — despite the widely publicized dangers of some of these substances, and despite the threat of legal sanctions. The situation raises questions about how long we can continue to use the criminal process to control drug use, and what other means are available.

References

1. *House of Commons Debates* (Canada), 1922, p. 1529.
2. King, William Lyon Mackenzie, *Report on the Need for the Suppression of Opium in Canada* (Ottawa: Queen's Printer, 1908).
3. *House of Commons Debates* (Canada), 1922, speeches by Rev. A. M. Carmichael (p. 2824) and by Hon. S. F. Tolmie (p. 3017).
4. Haywood, A. K., "Dangerous Drugs," *Canadian Medical Association Journal*, Vol. 13, No. 1 (January, 1923).
5. Murphy, Emily F., *The Black Candle* (Toronto: Thomas Allen, 1922), p. 16.
6. *Ibid.*, p. 17.
7. *Ibid.*, opposite p. 30.
8. *Ibid.*, p. 333.
9. Traswick, E. W., "Search Warrants and Writs of Assistance," *Criminal Law Quarterly*, Vol. 5 (1962), p. 362.
10. *Narcotic Control Act*, section 10, subsections 3 and 4.
11. Two examples are the comments by:
 - Morrison C.J. in *re* Chow Duck Yuct, British Columbia Supreme Court, 1931, in *Canadian Criminal Cases*, Vol. 55, p. 344; and
 - Martin J.A. in *Rex v. Lee Fong Shee*, British Columbia Court of Appeal, 1933, in *Canadian Criminal Cases*, Vol. 60, p. 73.
12. Robertson C.J.O. in *Rex v. Brezack*, Ontario Court of Appeal, 1949, in *Canadian Criminal Cases*, Vol. 96, p. 101.
13. "Medical Men and Narcotics—A Warning," *Canadian Medical Association Journal*, Vol. 18, No. 1 (January, 1928).
14. Senate Special Committee, *Traffic in Narcotic Drugs in Canada* (Ottawa: Queen's Printer, 1955), testimony of Dr. James G. Foulks, chairman of the Vancouver committee (pp. 187-188).
15. *Ibid.*, testimony of Supt. Edwin Brakefield-Moore, RCMP (pp. 399-400).
16. *Ibid.*, p. XVIII.
17. *Ibid.*
18. *Narcotic Control Act*, section 17, subsection 1.
19. "Good Medical Practice in the Care of the Narcotic Addict" (a report prepared by a special committee appointed by the

Executive Committee of the Canadian Medical Association)
Canadian Medical Association Journal, Vol. 92, pp. 1040-1043
(May 8, 1965). Reprinted in *Addictions*, Vol. 12, No. 2 (Fall,
1965), pp. 27-37.

20. *House of Commons Debates* (Canada), 1938, p. 772.

21. *Globe and Mail*, May 23, 1969, p. 14.

22. *Ibid.*

23. *Globe and Mail*, Oct. 18, 1969, p. 1.

L'auteur est conférencière en sociologie à l'Université de Toronto. Elle donne dans son exposé un aperçu des origines et de l'élaboration des lois sur les stupéfiants au Canada. Elle raconte que les premières lois promulguées au Canada contre les stupéfiants ont été en grande partie dictées par la crainte et la méfiance éprouvées à l'égard des Orientaux. Les législateurs avaient été portés à croire que les trafiquants chinois de stupéfiants entraînaient les hommes et les femmes blancs à s'adonner à l'usage des stupéfiants, ce qui les faisaient tomber en proie à une conduite immorale, particulièrement dans le domaine sexuel. C'est William Lyon Mackenzie King qui fournit le premier ce genre de renseignements à la Législature canadienne. Il avait fait une déclaration à la Chambre en 1908, exposant qu'il croyait être nécessaire de supprimer l'usage de l'opium au Canada. Plus tard, les autorités informèrent les législateurs que la marihuana rendait folles les personnes qui la fumaient et provoquait chez elles un comportement immoral et tendant à la violence. En conséquence, les lois canadiennes sur les stupéfiants se distinguent des autres lois du droit pénal par la sévérité des peines qu'elles imposent et par l'absence de la protection judiciaire traditionnelle vis-à-vis des personnes accusées d'infraction dans ce domaine.

The Dilemma of Drug Education

Educator: "If you take too much alcohol (heroin, methamphetamine), you'll ruin your life."

Kid A: "Okay, I won't take too much alcohol (heroin, methamphetamine)."

Kid B: "Oho, so *that's* how you ruin your life!"

—AMc

Daytop Village

By Alexander Bassin

A pretty co-ed from nearby Wagner College, fulfilling a class requirement for *Sociology 416*, "Social Problems in Modern America," visits Daytop Village on New York's Staten Island during a Saturday night Open House party. Soon she is in deep conversation with a young man who might pass as a college senior — except that he is neatly dressed, wears coat and necktie and his hair is short and combed.

"What is Daytop all about? What do you do?"

"I'll tell you right up front. We take a guy, say 25 years old, who's been a waste all his life. He's been stealing and robbing, and is in and out of jail. He's a thief and a parasite who would con his own mother out of her food money to buy some crap to shoot into his veins. And do you know what we do with him?"

"No, what? What do you do?"

"In a matter of a year and a half to two years, we transform him into an honest, decent, responsible human being who has a new set of values, who has some interests beyond the bang-bang on the boob tube, who knows a little something about art, music, literature and the war in Vietnam. In other words, we, like, take an order of scrambled eggs that has been spoiled and smells, and we change it into a sweet and cool lime jello pudding."

Dr. Bassin is associate professor of criminology at Florida State University. He was a member of the study team whose report led to the founding of Daytop Village and is still a member of Daytop's board of governors and a consultant to its board of directors. For some years he has been associated with Dr. William Glasser in promoting the use of "reality therapy" through workshops and institutes in all parts of the United States. This article is reprinted, with permission, from *Psychology Today*, Vol. II, No. 7 (December, 1968). Copyright © 1968, Communications/Research/Machines/Inc. Further information about Daytop Village can be obtained from the Administrator, Daytop Village, Inc., 184 Fifth Avenue, New York, N.Y. 10010.

"Gosh," murmurs the collegiate miss, "you Daytop people are wonderful."

The message gets through to the co-ed very well indeed. As well it might. The drug addict the young man is talking about is *himself*.

The psychological basis for treating drug addicts at Daytop Village differs radically from conventional methods. Neither punishing the addict by jailing him for extended periods nor slobbering over him with sympathy and pity has shown any great rehabilitative value. Nor has it helped to regard the addict as a sick person, a "medical problem" as some well-meaning folk put it. The Daytop philosophy is to consider the addict as an adult acting like a baby: childishly immature, full of demands, empty of offerings.

The addict sees nothing as his fault — not his addiction, not his degradation nor his desperation. He is convinced he has been thrown into life without the armor and weapons that others have. Heroin enables him to escape from the unfair battle. It deadens his desire for friends, for achievement, for wealth, for strength, for sex, and even for food. The satisfactions sought so relentlessly by other people, the junkie obtains — for a short time anyway — with a \$5 deck of heroin.

In pursuit of heroin, the addict is able to muster extraordinary cunning, shrewdness, gall, and acting ability. Usually he is untouched by normal psychotherapeutic approaches. For him treatment is a game of one-upmanship, an arena for practising his confidence-man skills.

Conventional methods of treating drug addicts have been grossly ineffective. For example, follow-up studies of addicts treated in the U.S. Public Health Service Hospitals in Lexington, Kentucky, and in Fort Worth, Texas, reveal that more than 90 per cent of released patients relapse into drug addiction within a few years. And many of the addicts treated at these excellent medical facilities do not show even the simple

respect for their \$50-a-day treatment of waiting 48 hours after release before taking a shot of heroin.

The change agent most likely to be effective with the junkie is another addict who has made a commitment to change himself, one who is prepared to use himself as a role model and become *involved* with his "brother." When a professional therapist attempts to communicate with the addict, he is simply turned off with: "This dumb bastard doesn't know what he's talking about. He doesn't know the scene. He's never been there."

The Daytop intake process is organized to challenge the sincerity of the applicant's desire to break his habit. Thus, when a kind-hearted social worker, psychologist, psychiatrist, judge, probation or parole officer telephones Daytop in an effort to smooth the admission of a "worthy" case, he is politely advised it would be best if the addict applied for himself or herself. The applicant should be over 16 years of age and not a pillhead. When withdrawal takes place outside the hospital, Daytop personnel consider the barbiturate, amphetamine and Methedrine addict to be in far greater danger than the heroin addict. In any case, the addict himself must telephone to arrange for admission to Daytop.

When the addict does call he is told that Daytop is crowded, many addicts are clamoring to get in, and space is limited. But if he is really interested in getting in, if he wants to make an "investment to save your life," he may call again tomorrow at 2:30 sharp. If he "forgets" and calls a day late, he is told, "I guess you're not very serious about helping yourself. So we are putting you at the bottom of the list." When he calls at the designated time, he is commended for his interest and told to call again a day later. If this commitment is kept, he is invited to present himself at Daytop Village, clean of drugs for at least 24 hours, with his parents and family if possible. Some applicants go through half a dozen telephone calls before they receive an invitation.

What is the rationale for this apparently heartless system?

Few addicts are motivated for therapy and change. Treatment is usually the lesser of two evils to the junkie. He comes to Daytop because he thinks it is "easier time" than jail, or because there is a panic in the streets and no drugs are around anyway, or because the heat is on and he needs a hideout, or because he has been kicked out of the house by his wife, or because he wants to dry out for a while and is tired of finding ways to pay for his expensive habit. But permanently give up the use of junk? Impossible! Once a junkie, always a junkie. So the addict reasons with himself about the prospect of going straight.

Every step of the Daytop intake procedure is designed to shock the addict into realizing that this place is basically different from the social agencies he has learned how to manipulate. Here he will not be indulged like a spoiled child, here his usual con games will not work.

When the addict arrives at Daytop on the scheduled date and on time, he is admitted to the reception area and told to sit on the "prospect's chair" and wait until he is called. Meanwhile, his parents and relatives are ushered next door and given counsel that makes their jaws drop as tears come to their eyes.

"Mama, here at Daytop we don't blame parents for the misdeeds of their children. We know you never encouraged him to use dope but he's always tried to make you think it was all your fault. He's stolen money from you, lied to you, abused and cursed you, made your life a hell on earth. How do we know all this? Did we read it in some book or in *Life* magazine? No, mama, we are all ex-junkies, just like your Johnny, and that is what we did to our own parents."

Members of the interviewing team then give the relatives thumbnail autobiographical sketches of themselves. Next, each extols the near-miraculous benefits of a year or two at Daytop.

Finally, the parents are given some astonishing advice: Make yourselves as cold, as hostile and rejecting as you can

towards Johnny. If he telephones, hang up! If he sneaks out a letter, return it unopened to Daytop. And if he suddenly turns up at home and turns on the woebegone, contrite mannerisms the addict puts on so well, if he tries to melt your hearts with tales of the abuse he suffered at the Village, then grit your teeth and tell him, "Go back to Daytop, get lost." And slam the door in his face.

Meanwhile, back at the reception desk, the prospect has been going through a nerve-shattering experience. He sits facing a wall. Behind him is the open door — and freedom. By now, he has cased the setup and notes that there are no bars anywhere, that the windows are at ground level — and wide-open. All about him is the hustle and bustle of a happy family household rather than the aseptic silence of a hospital or of a prison. Nobody is walking around in hospital pajamas or prison uniforms; there are no doctors with stethoscopes hanging out of their pockets, no nurses in white uniforms, no uniformed security personnel.

Then he sees a blood-brother, a crony with whom he had shot up only a short time ago in alleyways and public toilets — sharing the same spike. But instead of the warm welcome he would have received in any prison or hospital in the country, his former pal looks through him as though he were invisible, and doesn't respond to Johnny's big hello.

Momentarily uneasy, Johnny relaxes with the thought that junkies will be junkies. They must have a supply stashed away someplace, and once he gets into the swing of things, he will be able to cut himself into the action. For the third time in 20 minutes, he asks when he will be interviewed. His frustration tolerance is low, and he has never willingly waited for anyone.

"We are very busy here, as you can see, and you will have to wait until the interviewers can see you," the receptionist answers coldly. The implication is clear; if he doesn't like it, he can beat it. No one is keeping him. He may wait from 45 minutes to four hours before being called for the

interview. If he does not flee through the open door, he passes another initiation rite for admission to the Daytop fraternity.

The interview room is cozy, homelike, a room without desk, or diplomas, or any of the accoutrements of the professional office. Three clean-cut, conventionally dressed young men politely ask Johnny to come in, apologize for the delay, and start questioning him in a kindly, sympathetic manner. What did he want from Daytop? What was the problem? What neighborhood did he come from?

Within a few minutes, Johnny has sized up the situation. These cats are obviously social workers and he can con them out of their bank accounts if he really tries. He talks to them about his hard and sad life, about his fears and anxieties, his unresolved conflicts, his determination to be cured of the horrors of drug addiction and to make himself over into something better.

Suddenly, one of the interviewers jolts Johnny:

"Hey, stop this garbage! Who the hell do you think you're talking to?"

Two of the interviewers talk to each other: "Did you ever hear such bullshit in your life?"

"This crazy dope fiend thinks he's inside another joint."

"Maybe he didn't get enough luff from his mudder and fodder!"

The interviewers curl up with laughter and poke one another in the ribs as they mimic the addict's words and expressions. After a few minutes, they turn serious and begin a "cleanup" operation. No, they are not social workers, psychologists, intake workers or whatever he thought they were, but street junkies just like him.

Right now they can tell him just what is going through his mind because junkies are pretty much alike. They are under the impression the world owes them a living because they are hooked on dope, and they dare anybody to cure

them. But here at Daytop you learn "there ain't no free lunch."

They tell Johnny that despite his physical size and age, he is a baby in terms of maturity, responsibility and judgment. So he will be treated like a three-year-old who is told what to do because at this point he simply does not have enough sense to keep from getting killed.

"You'll see a lot of things you don't understand. Don't waste time asking a lot of fool questions. Your brain is not strong enough for that kind of exercise just yet. Maybe in a few weeks or months you will understand. But for the time being, you must *act as if* you understand, *act as if* you are a man, *act as if* you want to do the right thing, *act as if* you care about other people, *act as if* you are a mature human being."

At Daytop, Johnny is told, we don't spend valuable time trying to find the essential *cause* of his addiction. That whole process would be exploited by the addict to avoid the responsibility for his behavior. At Daytop we *know* why somebody is a dope fiend — because he chooses to act STUPID! That's the only acceptable explanation for addiction: *stupidity*.

At the end of the interview, the "noodle-head" is told there are only two cardinal rules of the house:

1. NO CHEMICALS OR DRUGS OR ALCOHOL MAY BE USED.
2. NO VIOLENCE OR EVEN THE THREAT OF VIOLENCE.

No excuse is accepted for breaking either of these two basic rules. If he does, he will be kicked out, exiled.

The interviewers now become affable. They say that Daytop is one place where the people really care for one another, treat each other like brother and sister. Everybody tries to live as openly and honestly as possible. No con games, manipulations, lying or cheating. Everybody in the house, from the director to that girl at the reception desk, is a junkie. There's no "we versus they" business here. Everybody is a member of the staff, and there's no job he can't aim for — even director.

Johnny is assigned a low-status job at once. He cleans the toilets, washes pots and pans or mops floors. He is introduced to his three roommates who have been trained to welcome him to their midst and to assume responsibility for the welfare of their new brother.

If he is experiencing any withdrawal symptoms, no big fuss is made about it. He goes through the withdrawal on a couch in the living room with residents all about him, laughing, playing cards, listening to music, dancing. He is too ashamed to put on the expected exhibition of wall-climbing and swinging from chandeliers. He knows that these people will not be impressed by his performance. He knows there will be no payoff for his histrionics from these wise, hard-nosed critics. And somewhat to his own surprise, he kicks the remnants of his habit in record time with no more discomfort than the average guy with a mild case of flu.

One of the principal methods for achieving self-image and behavioral change at Daytop is the three-times-a-week *group encounter* therapy.

During the encounter, in which attendance is compulsory, the building echoes with ear-piercing screams, curses, oaths, blasphemy, shouts, tears and laughter. The vehemence is hard to believe. Gutter language and four-letter epithets explode from the rooms. One member after another is assigned to the "hot seat," where he is attacked and criticized for failing to adhere to the basic precepts of Daytop, for being less than 100-per-cent honest and open, for being insensitive to the feelings of others.

The encounter is called a *pressure cooker*. As one staff member puts it: "It is a safety valve to relieve the tensions that have built up during the previous day. The Daytop resident cannot use profanity at any time except during the encounter. He cannot act moody or irritable or be overcome with self-pity between encounters. He has to *act as if* and wait until the encounter to get the garbage out of his system. The encounter is a gut-level teaching device that speeds up

personality alteration, just as a pressure cooker speeds the preparation of food."

Many professionals are abashed and frightened by the fierceness of the attack therapy. But Dr. Lewis Yablonsky, research consultant to Synanon, after his first 25 sessions, found that the group "attack" was an act of love in which was entwined the assumption: "If we did not care about you or have concern for you, we would not bother to point out something that might reduce your psychic pain, or clarify something for you that might save your life."

Every day but Sunday, at one o'clock, the Daytop membership assembles in the auditorium. Before them, on a blackboard, they see a quotation, perhaps from Emerson, or from Einstein. It may be a Biblical quotation or a poem by Emily Dickinson.

A different leader is appointed for each seminar. He asks: "Who wants to say something about this?" Before the words are out of his mouth, a dozen hands are waving in the air. The leader points and a member rises, nervous and uneasy. He mumbles a few words, and sits down to a broadside of friendly applause. For an hour, the performance is repeated with speakers of differing degrees of fluency.

Other seminars feature free choice sessions, in which residents talk spontaneously about a designated topic, or mock speaking engagements, in which members act as if they are appearing before an outside community group.

A visitor to Daytop sees signs and slogans prominently hung in the kitchen, dining room, offices and hallways. Typical slogans are:

There is no free lunch.
Honesty *is* the best policy.
Hang tough! (Don't give up.)
Seek and assume responsibility!
Be careful what you ask for:
You may just get it!

Every resident seems to incorporate these shorthand be-

navorial prescriptions into his speech repertoire. You hear them spoken at encounters, seminars, and while "rapping with the squares" (talking to non-addicts) at the Saturday night Open House party.

If a Daytop resident commits the heinous offence of "splitting" (leaving without permission), an emergency Fireplace Meeting might be called when he returns, even if it requires routing everybody out of bed at three in the morning. He is placed on the hot seat and must beg at the top of his voice to be readmitted into the house. Sometimes he is subjected to a "haircut," a severe verbal reprimand. And if his offence is serious his hair is actually cropped to the skull while house members boo and jeer.

The director of Daytop at Staten Island once told me: "An errant member submits to a haircut to show he is sincerely sorry for the stupid thing he did and that he wants to make a solid investment in his recovery. His bald head helps him remember not to act stupid and irresponsible in the future."

Banishment is the most serious sanction at Daytop Village. But it is reserved for a flagrant violation of the house rules. Exile is considered equivalent to a death sentence — an all-too-frequent fate of the junkie, who can end up on a marble slab at the city morgue, dead of an overdose.

The greatest number of dropouts in the Daytop program occurs during the first 30 days. About eight per cent of the addicts who come through the front door leave immediately or within a month. The great majority remain for three months, when another critical period is reached. Approximately 17 per cent will split after 90 days. According to Dr. Daniel Casriel, medical-psychiatric director of Daytop, the addict who remains three months has better than a 75-per-cent chance of completing the program and emerging as a new vibrant human being.

Staff members of Daytop, on the other hand, refuse to become involved in a numbers game about the success rate

of Daytop. They note that besides the several hundred residents of Daytop who are leading lives free of drugs and crime, there are more than 60 who have met Daytop's extraordinarily high standards for personal transformation and are leading active and self-supporting lives in outside communities.

Every three months or so, a marathon encounter led by specially trained staff members is held. Basically, the marathon is an extension of the floor encounter for a period of 24 to 48 hours. The meeting is continuous except for a few hours of sleep. In many cases, there are experiences of rebirth and personality alteration that have no exact parallel in psychiatric literature.

Twice a year, Daytop closes its doors, unhooks the telephone, calls in all members, and engages in a week-long retreat. It is a time of self-criticism, meditation, institutional assessment, and charting new directions.

On Saturday night, Daytop Village is open to visitors. A phone call will reserve a place, but frequently every opening is filled weeks in advance. This Open House has become a favorite field-trip assignment for professors of psychology, sociology and education. There are some speeches followed by music and dancing, but the best part, most visitors agree, is the opportunity to talk with a remarkable group of intelligent, alert, healthy-minded young people.

About seven years ago, a team consisting of the late Professor Herbert Bloch, criminologist at Brooklyn College, Dr. Daniel H. Casriel, a psychiatrist with many years' experience in treating addicts, Joseph A. Shelly, chief probation officer of the Brooklyn Supreme Court, and myself, visited and evaluated the leading narcotic treatment centres in all parts of the United States. Nothing very exciting turned up until we came to a little-known, converted armory located on the beach of Santa Monica, California. Here our psychiatrist was surprised to find several former patients of his that he had dismissed as hopeless. But here they were healthy

and happy, and most important of all, they were free of drugs!

The place was Synanon, and its founder, Chuck Dederich, assured us that it was destined to become one of the most significant developments in treating not only drug addicts but all forms of deviant behavior, even chronic criminals and the so-called psychopath.

In a gravel-toned voice, our bull-necked host explained his approach in anthropological terms: "We attempt to create an extended family of the type found in preliterate tribes which usually have a strong, almost autocratic, father-figure, who dispenses firm justice combined with warm concern, who is a model extolling inner-directed convictions about the old-fashioned virtues of honesty, sobriety, education and hard work."

Our mission experience resulted in a proposal to the National Institute of Mental Health for the establishment of a halfway house for drug addicts on probation, who would be treated along the lines we observed at Synanon, except that they would be regularly tested for traces of heroin. On April 15, 1963, we were informed that NIMH had awarded us \$390,000 for a five-year study.

For a name we selected the acronym *Daytop* (Drug Addicts Treated on Probation) and *Lodge*, to avoid the unfortunate semantic associations with orthodox treatment centres.

Our first manager was driven to the verge of a nervous breakdown by the antics of the residents and the problems of setting up a pioneering experiment under the aegis of a court bureaucracy. In the first year the project chewed up half a dozen managers. At the same time, residents of the local community protested against the presence of Daytop with picket lines, law suits and angry letters in the local newspaper.

The turbulent development of Daytop was stabilized with the acquisition of a new manager, a native of Chicago with

a history of some 14 years of addiction. He curbed his habit at Synanon, rose to a position of leadership there, but left after two years because of some differences with Dederich.

Although conditions at Daytop improved under the new manager's leadership, a plateau was reached that called for a re-evaluation of methods and goals. Up to this time, only male addicts had been admitted. It was decided that the small initial group of 30 males did not provide the diversity of personality types required to operate the dynamics of a therapeutic community. According to the director, "The junkie needs new faces on whom to try out his recently acquired skills. It is necessary to create a community of men, women and children who live and work and love together if our people are to grow into mature responsible citizens."

NIMH agreed to permit the original research plan to be expanded and to the inclusion of females. The name of the project was changed from Daytop Lodge to Daytop Village.

Today, Daytop is operating a 100-resident facility at Staten Island, another with a capacity of 200 at Swan Lake in the Catskill Mountains, about 120 miles from New York City, and a third on New York City's West 14th Street.

Methods developed at Daytop are being applied to new fields. For professionals, such as psychologists, social workers and clergymen, Daytop has conducted several hundred Intensive Training Institutes at its centre in the Catskill Mountains. Participants become members of the Daytop community and experience the encounter process. They come to grips with their own emotional and social problems. Almost all emerge with the comment: "This has been one of the most meaningful experiences of my life."

Daytop has established three store-front centres called SPAN, which are designed to induce the street addict to sample the Daytop approach. These centres also work directly with people in the ghettos to improve their community.

Abraham Maslow, president of the American Psychological Association, and O. Hobart Mowrer, a former president, both have proclaimed Daytop as one of the great therapeutic community developments of our time. Mowrer is now writing a book on Daytop, *The Daytop Dynamic*.

Daytop is optimistic about its future. The leading force in the organization of Daytop, Monsignor William B. O'Brien, sees the principles and methods developed there as useful not only for the rehabilitation of narcotic addicts, but also for the training and revitalization of teachers, psychologists, psychiatrists, social workers, businessmen and government officials.

"The Daytop approach can be used in prisons, penitentiaries and reform schools," he says. "As a fellow priest once remarked to me after spending a month at the Village: 'God is not dead, He lives at Daytop!' People in all helping professions can learn from Daytop how man can be taught to help himself."

L'auteur, psychologue sociologue, était membre d'une équipe d'étude dont le rapport a mené à la fondation de Daytop Village. Il est toujours membre du Conseil des gouverneurs de Daytop et fait fonction de conseiller à son Conseil d'administration. Daytop Village est une maison de réhabilitation pour toxicomanes, dans laquelle d'anciens toxicomanes s'entre-aident pour vivre sans se droguer. Le programme suivi par Daytop est fondé sur la conception inverse mise en pratique dans les institutions et les thérapeutiques ordinaires de réhabilitation. Les institutions de réhabilitation courantes tendent à considérer les toxicomanes comme des "malades" qu'il "faut aider." Les anciens toxicomanes qui sont à la tête du programme adopté à Daytop considèrent que le toxicomane cherche, par manque de maturité, à jouer un rôle pour se gagner la confiance de ceux qui s'intéressent à lui, et qui pense que le monde se doit de pourvoir à sa subsistance justement parce qu'il est toxicomane. La conception qui se trouve à la base de la plupart des thérapeutiques psychologiques ordinaires veut que les progrès s'accomplissent chez le patient dès que celui-ci parvient à mieux élucider les causes profondes de son propre problème. Les pensionnaires de Daytop exigent du nouveau venu qu'il se comporte en adulte dès son arrivée, que cela lui plaise ou non. Ils l'aident ensuite à raisonner comme

un adulte et enfin à se sentir comme un adulte. Le principal élément thérapeutique consiste en réunions de groupes dont les discussions sont basées sur la conception que le toxicomane est parfaitement capable d'apprendre comment se comporter en adulte, que ses compagnons, anciens toxicomanes, ont le droit de l'exiger de lui et qu'ils peuvent l'aider à atteindre ce but.

The Daytop Philosophy

We are here because there is no refuge, finally, from ourselves. Until a person confronts himself in the eyes and hearts of others, he is running. Until he suffers them to share his secret, he has no safety from it. Afraid to be known, he can know neither himself nor any other; he will be alone.

Where else but in our common ground can we find such a mirror? Here, together, a person can at last appear clearly to himself — not as the giant of his dreams nor the dwarf of his fears, but as a man, part of the whole, with his share in its purpose. In this ground we can each take root and grow, not alone any more, as in death, but alive — to ourselves and to others.

—RICHARD BEAUVAIS

A.A. Addictions

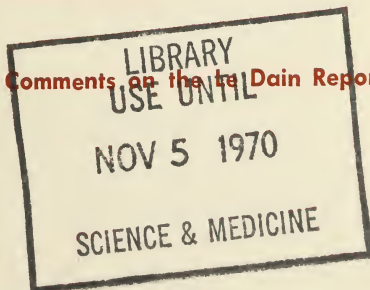
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An AA Meeting in the Early Days

By Harold Maine

The entrance to the AA meeting place reminded me a little of a speakeasy. We turned down a low-numbered street on the West Side and stopped before a door with only a street number on it. A man on guard just inside the door smiled at us and let us enter. We then went down a long passageway that opened into a clubroom. It was panelled and comfortable-looking but where once lounging chairs had been there were now folding chairs placed in rows. Over the fireplace were the words BUT FOR THE GRACE OF GOD. . . . Stairs led up along one wall into another part of the headquarters.

The meeting had not started yet and men and women were standing around a Coke dispenser in the corner. They were a happy, laughing group, at ease and sure of their companions. Yet none of the faces I saw would have been at all out of place among the league of lushes at the tavern I patronized. I looked at the sign above the fireplace again.

This story is a section of the late Harold Maine's autobiographical work, *If a Man Be Mad* (Garden City, N.Y.: Doubleday & Co., Inc., 1947); it is reprinted with the permission of his first wife, to whom he left the copyrights of his books.

BUT FOR THE GRACE OF GOD. . . . It made something in me cringe. I wished that it had not been there.

Justin wanted to introduce me around but I excused myself on the grounds of illness and took one of the camp chairs. People came and introduced themselves to me anyway. All seemed delighted that I was there. Though Herman had a national reputation and his picture often appeared in the papers, they were much more interested in me than in him. For once my shakes and fearfulness marked me as a man of importance. Two or three asked if they might call on me and wanted my address. Almost everyone sympathized with the quite obvious tough go I was having. Then the meeting was called to order.

The chairman introduced himself with a brief autobiographical sketch, confined to his drinking experiences, to identify himself as one of us. There was no doubt that he had been an extraordinarily ardent alcoholic. I was relieved when he said nothing of his salvation. To me it was enough that he was standing there sober. Then briefly, for the benefit of people who were there for the first time, he explained more about the organization. There were no dues, no fees, and no membership forms; all that was required was the admission that a person was powerless over alcohol. He also made it clear that outside of a collection taken up for the rent and expenses, and administered by a non-alcoholic, no money was to change hands in the clubhouse. Anything he said, outside these simple rules, came only from him as an individual and in no way represented Alcoholics Anonymous.

From then on the meeting consisted of a review of the Twelve Steps, also for the benefit of newcomers. As each was read some member would hold up his hand and be allowed to take the floor. Always there was the brief identification as an alcoholic, the emphasis that each person was speaking for himself, and then a personalized explanation of the step under discussion.

Had I been a few weeks away from alcohol much more

would have penetrated my drink-barricaded brain. But I had no bottle and did not know how long the meeting would last. The rule that no money would change hands in the clubhouse struck me, the more I thought of it, as an organized bit of indifference to a man in my position. Drunk, and with my paranoid drive sloshing through every decent human instinct, I could survive for a while. Sober and cringing before every law, ethic, and moral, equipped with pride again, I would starve and sleep in the subway if I could find a nickel. The only thing that held me in my chair was having Herman with me and the knowledge that in my room, locked in a bag, were six bottles of rubby-dub. To a man like me such a cache can mean more than a paid-up endowment policy to a solid citizen. It is security, wealth. I was cynical about gambling.

The attitudes of the various members to the "steps" with God in them were quite different. One thing almost all had in common was in professing to have had a spiritual experience. One man, addressed by the Chair as a doctor, said that he had had none but that his mind was open and that he felt this to be almost the equivalent of a spiritual experience for him. When I looked at the doctor I sensed that his mind was no more open than my own but that he thought it was merely because he was willing to sit and listen to men recount tales of such experiences.

Another man, who had the ardor of a revivalist, took the doctor to task for this. He had openly and wholly laid his sodden spirit at God's feet and all must do so. I could hardly sit in my chair but I was cheered when the doctor replied by giving a rather involved psychological explanation of the danger of other excesses than alcohol, particularly religious and emotional excesses. Justin took the floor to explain for the benefit of newcomers that each man's experience could not be other than truly personal.

"Then how are we to carry our message?" the fanatic asked.

The part of my mind that listened ran into a dream of drink and hid itself. That sticky sweat was starting, the tremors, the nervous stomach. My isolation was now, I felt, complete. I was cut off from all this group had to offer by the presence of the ghost of God.

Then with a surge of relief I saw that the meeting was coming to a close. But no, a figure sitting on the stairs, one I had not noticed before, was called upon to say a few words. He was simply called Bill. At first my only interest in him was in how long he would talk, but as he came slowly and tiredly down the stairs, walked slowly across the room to the fireplace, and leaned slackly with his elbow on the side of it, I knew that here was a unique man. He was tall and not heavy, his face was gray—even grayer than his hair—and was more masklike than Justin's. You might have thought that he had suffered a slight stroke if you did not know that he was an alcoholic who had ridden his addiction nearly to the end. Had he been leaning at the end of a bar, a place where you most certainly would have expected to meet him, he would have made every person there apprehensive. He was the ghost of a once powerful man, anyone could have guessed, a man who had had everything and found it without value, a man, in fact, who had no illusions and had played with life as one might with checkers. Even though my nerves were quivering like an aspen, my mind practically locked into the solitude of craving, and my body slowly rendering itself of its sticky juices, I was impressed. More than that, I was held in anticipation.

He must have stood for at least a minute without saying anything. But this was not for effect. A brain, tired from having experienced so much and valuing so little, has more trouble in selecting words to which it, itself, can bear to listen than the mind of a limited man. Even when words came, they were slowly uttered, each for its solitary value. The voice was low but it carried, penetrated. No one was addressed directly, not even the audience as an entity. It was

a detached voice, almost unearthly. The hair stood up on the back of my neck.

My retention was almost at zero. I can't recall a single sentence of what Bill said. I only know that without rhetoric or trickery everything that had been said in that room on that evening was being put in order. Yet no one, neither the fanatic nor the materialistic doctor, could have taken exception. There was no reproach or rebuff; no acclaim for someone's particular contribution. The whole delivery and its essence were peculiarly off centre. No personality was insinuating itself into the other men's minds—at least not directly. You could look at Bill and imagine that he was listening disinterestedly instead of talking, for the lips barely moved. I looked at Herman. His face was a little pale. He looked at me uncomfortably.

As I say, I was merely experiencing the man vaguely, but it seemed to me that everything that had been said on that evening, even the things I resented, had been essential, and even uncannily planned to give an effect to what Bill had to say. From something he said I became indirectly aware that he was the founder of Alcoholics Anonymous, but I was also aware that he was giving a personal disclaimer for the movement. He wasn't humble or proud. As a person he was trying not to be there. Only as an impersonal experience was he asserting himself.

I always mistrust men who have an immediate effect on an audience. I mistrust spine-tingling reactions, unless they are aroused by art, the way some symphonies, paintings, poems, and books arouse me. I feel that a reputation, based largely on folklore, tradition, or publicity, is asserting itself. I try to remove the man from this and see what he has. I also try to remove the name of an artist in the same way so that I can have his creation directly. If the name of the great Shakespeare in itself makes me respond, then I lay him aside until he no longer has that effect. It's the only safe way. I didn't mistrust Bill. I knew why he had selected the

word "Anonymous" for the organization as soon as he spoke.

I can only wish that what happened next hadn't happened.

Bill was suddenly through and the Chair arose. "There will be coffee after the meeting and you can hang around as long as you want," he said. "We will now close by repeating the Lord's Prayer."

My response was childish, I know that. But those words, uttered so many times back in the horror of my childhood, droned by fools and hypocrites, salvoed at me by deacons and dunces, destroying, I felt, all love, joy, hope, pride, and individuality, and murdering dignity, now destroyed Alcoholics Anonymous for me. Bill's lips moved too.

"I'm sick, I've got to get out of here," I said to Herman, tensely and urgently.

He nodded, for he understood. And then I actually was ill in the taxi. None of the food I had eaten on that day had been digested. At four in the morning I changed hotels, leaving Herman and Alcoholics Anonymous behind, as well as the addresses and phone numbers I had been given. For two days I subsisted on rubbing alcohol. I'd fight the battle alone, I thought.

But did I fight alone? I don't think so. I depended on the bonds of other people's friendship to Jean* or me to produce victims, and all the while I was crucified on the bitter angle guilt cuts across the rigid upright of each American's puritanism.

What I have written here is not a criticism of Alcoholics Anonymous. I delineate, and for me painfully, one man's response. That man wasn't a product of my intellect. That man was trying to destroy whatever intellect I had. The mind desired survival, but he was bent on indirect suicide.

* Maine's second wife.—*Ed.*

Summary with Comments on the Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs

By the Addiction Research Foundation of Ontario

The *Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs* sets out to be primarily a working paper which presents an agenda for consideration and further investigation. Only on questions which the commissioners felt could not wait for their final report have precise recommendations been offered, and even some of these have been put forward as interim measures pending further study.

The main text of the interim report contains the following six chapters:

1. "The Commission's Interpretation of Its Task."
2. "The Drugs and Their Effects."
3. "The Extent and Patterns of Non-Medical Drug Use in Canada."
4. "Some Causes of Non-Medical Drug Use."
5. "Present Canadian Policy—The Law."
6. "The Issues—Some Interim Recommendations."

This report is an outstanding document. Considering the short time in which the Commission has been in action, and the size and complexity of the problem it faces, we believe that it has made a major contribution to public education in this field. If the tone of scientific objectivity, human understanding and philosophical balance shown in the interim

This document was submitted to the Minister of Health for the Province of Ontario, the Hon. Thomas L. Wells, in July, 1970. For this reprinting, the appendixes have been dropped and references to them in the text have been eliminated. A number of copies of the full text, with appendixes, are available on request from the Information Officer of the Foundation.

report are sustained, its final report will be a classic of its kind.

As we indicated in our preliminary brief to the Commission in December, 1969, governmental policy decisions in the area of drug controls must ultimately depend on value judgements and considerations of social and political feasibility, as well as on scientifically ascertainable facts. Full public discussion of all these components of decision should be much easier and more productive as a result of this interim report.

Chapter 1 outlines and interprets the Commission's terms of reference. It gives reasons for including in its studies not only what are colloquially termed hard and soft drugs but also alcohol. They state:

We have had a growing concern for the facts and implications of the use of drugs such as alcohol and tobacco by people of all ages. These two drugs, both of which are psychotropic, remain the most popular drugs in non-medical use among both young people and adults. Adults generally seem unwilling to accept the fact that alcohol and tobacco are drugs, and often find it difficult to view the non-medical drug use of youth with reference to and in the context of the socially acceptable use of drugs by adults. (Sec. 4)

They also point out that non-medical use and illegal use are not necessarily the same. For example:

The occasional use of aspirin to control the pain of an ordinary headache is considered to be medical use, while the dependent use of large quantities of barbiturates obtained through one or more prescriptions is not. (Sec. 5)

The use of alcohol by adults is generally non-medical but it is legal, whereas the use of marijuana is both non-medical and illegal. (Sec. 5)

Chapter 2—"The Drugs and their Effects"—reviews in detail what is known about the nature and effects of eight basic classifications of drugs or substances: barbiturates, alcohol, minor tranquillizers, amphetamines, LSD, cannabis, opiate narcotics, and volatile solvents. The complexity of the subject makes it impossible to summarize briefly; suffice it to say that in every case medical uses, routes of action, physiological and

psychological effects, tolerance and dependence characteristics and cross-effects with other drugs are well covered. Out of 237 numbered sections in this one chapter, the staff of our Research Division have been critical of only 29. . . .

Chapter 3—"The Extent and Patterns of Non-Medical Drug Use in Canada"—indicates that the Commission will be conducting a survey of its own, partly in order to narrow the range of data in various estimates that it received, which was approximately as follows:

Drug	Range of estimates of use by youth in high schools
Alcohol	40.0% to 88.0%
Barbiturates	1.5% to 3.3%
Tranquilizers	6.0% to 27.3%
Amphetamines	3.6% to 9.7%
LSD	0.5% to 3.0%
Cannabis	5.9% to 24.0%
Solvents	2.0% to 13.0%

For opiate dependence the Commission presents data from the Division of Narcotic Control, Department of National Health and Welfare, indicating that for all ages there are about 4,000 known addicts in Canada of whom 23% are in Ontario. The Commission does not yet have satisfactory data as to whether or not youthful users of opiates (1.5% of "criminal addicts" in 1969) are increasing in Canada as has been reported in the U.S.A.

The Foundation is pleased that the Commission intends (Secs. 273-274) to undertake an extensive survey of the extent and pattern of drug use in Canada, and would like to suggest three types of survey which are possibly of the greatest urgency:

- (a) full quantity-frequency surveys (cf. Sec. 305 of the report, indicating from several surveys that many "users" of cannabis had done so very few times);
- (b) surveys of attitudes and values among the general population, with respect to drug use and drug laws, as an aid in

formulating government policy and assessing feasibility of legal changes; and

- (c) selective re-survey of areas or populations already surveyed, to detect trends in drug use.

One general comment we wish to make on Chapter 3 relates to the absence of any reference to the frequency distribution studies on alcohol use (de Lint and Schmidt, *Quart. J. Stud. Alc.* 29: 968, 1968). We believe these studies to be of major importance because they establish the existence of a unimodal distribution curve for alcohol consumption, in which any factor which raises average per-capita consumption by the whole population also raises the proportion and absolute number of heavy users. The available evidence, though not as complete as for alcohol, indicates a similar pattern for other drug use (Smart, Whitehead, and Laforest, A.R.F. Substudy 3—7 & Wh & La—70). This point should be made in Chapter 3 because it is highly relevant as preparation for Chapter 6, about which more will be said later.

These studies carry implications for social policy and for education in relation to alcohol and other drug use. In essence, they demonstrate that there is no clear distinction between “normal” or “moderate” users on the one hand, and “heavy” users or “abusers” on the other. All users fit on a single curve falling smoothly from a high frequency of very light consumers at one end, to a small frequency of very heavy consumers at the other end. The distinction between them is a purely quantitative one, and is made by selecting on empirical grounds some level of consumption which is designated the upper limit of “normal” or “low-risk” use.

Since social acceptance plays a major role in determining the slope of this frequency distribution curve, anything which raises the level of acceptance tends to displace the whole curve towards the higher-consumption end, so that a larger absolute number of users exceeds the limit of “low-risk” consumption. Legal measures, social controls, and educational programs may therefore have to be aimed at reducing the

general level of acceptance and use, if they are to have any success in reducing the frequency of heavy use.

Chapter 4—"Some Causes of Non-Medical Drug Use."

This chapter presents a very wide-ranging and compassionate view of the various factors in individual motivation to drug use.

While some of the staff of the Foundation's Research Division have raised objections to the admitted use of the "art of the novelist"* in probing motivation to drug use, most of them are in sympathy with this approach. Many aspects of motivation are not yet susceptible of scientific analysis, yet they are nevertheless quite real and valid. Some criticism has been expressed in the press, . . . and by some members of the Research Division, of the acceptance at face value of stated motivation, such as a desire for transcendental experience or a search for identity. However, we would accept this as at least a legitimate part of the exploration, because such a longing may possibly be quite real even among those who cannot articulate it and are therefore dismissed by some. If we are not to accept such reasons at face value, why should we accept any more readily a statement that drugs are used just for "kicks"?

However, we believe that Chapter 4 has shortcomings which we hope will be remedied in later reports. One is the relative lack of emphasis on the contribution of social pres-

* "Although we intend to inquire further into motivation (as well as extent of use, perception of the problem, and general attitudes) in the surveys to be carried out this year, we do not necessarily rely on the answers to survey questionnaires as the most reliable evidence of motivation. Motivation is too subtle, complex, and full of nuance to be adequately elicited through questionnaires. We place as much or more reliance on the impressions derived from hearing individual drug users speak at length in public and private meetings about their experience and what they think to be the causes. In many ways we are closer here to the art of the novelist than that of the social scientist."—*Interim Report*, Sec. 319.

asures for drug use, such as example, availability, fad, etc. The individual factors discussed in the report may provide the drive, but social factors must be very important in providing the direction towards drug use. For example, even for those who say they use cannabis merely for "pleasure" (Sec. 321), why do they obtain pleasure by using something illegal, which carries substantial risks, when other "mild intoxicants" are available with no legal risk?

The commissioners stress that the views reported in this chapter do not, even for the Commission, constitute a full conceptual framework for understanding non-medical drug use; rather they are impressions which the commissioners intend to test as vigorously as possible by intensive investigation and by inviting critical comment.

It is difficult to summarize this material, but a few key sentences are quoted here:

We feel it would be a serious error, at least as far as cannabis use is concerned, to think of use as symbolic of or manifesting a pathological, psychological or even sociological state. Simple pleasure, similar to that claimed for the moderate use of alcohol, or food, or sex, is frequently offered as the general explanation for most current drug use. (Sec. 322)

We gather from the statements of cannabis users that the drug is predominantly used in groups to enhance, enrich and ease social intercourse. However, the statements of LSD users imply that their experience is much more. LSD is spoken of as a very profound experience, not to be lightly entered into. With some it is never to be repeated; with others, its profound character, the sense of venture into the unknown, the very real risks of adverse effect, make it a practice which seems likely to remain fairly restricted. It is cheaper than psychoanalysis but appears to carry with it some of the same implications: the promise of greater self-knowledge and self-acceptance, but at the same time uncertainty as to the personality that will emerge. (Sec. 327)

There is no doubt that a search for self-knowledge and self-integration and for spiritual meaning are strong motivations with many. We have been profoundly impressed by the natural and unaffected manner in which drug users have responded to the question of religious

significance. They are not embarrassed by the mention of God. (Sec. 329)

There is an active doctrine of transcendence which sees drug use as a catalytic or transitional thing to be abandoned as soon as it has enabled you to glimpse another way of looking at things and of relating to life and people. (Sec. 330)

We suspect that much contemporary drug use simply serves the purpose of relieving the stress and tension which most people, young and old, experience in modern living. Certainly this is a dominant function of alcohol, and nicotine which are still the most prevalent drugs in all age groups. . . . It is also true of the large quantities of barbiturates consumed by adults. (Sec. 344)

Many observers tend to characterize the psychological predisposition to the use of *methamphetamines* ("speed") as one of deep depression. . . .

The 'speed freak' can be seen as a casualty of the increasing complexity of the demands for adaptation and survival in a technological society. (Sec. 346)

Many young people profess to have little belief in the future—to find it difficult to visualize a future for themselves. In one small group we met with during our hearings one of the women said, "Very few in our generation believe we are going to live to be forty." There was general agreement in the group with this statement. (Sec. 347)

The Commission has very often been told by young people that they reject all that is traditional, conventional and stereotyped, because they consider it to be hypocritical, phony, dehumanizing, threatening, and ugly. As a result, they may become alienated and some may be plunged into a frantic search for an identity which may be acceptable to them by their own standards. This search for identity may go in two directions: one leading to pathological adjustment—the other simply to a non-pathological parting from conformity. (Sec. 352)

The sick individual who relies on cannabis, speed or other psychotropic drugs, almost as his only means of escape, who uses them always as a crutch and structures his whole existence around them as the only providers of pleasure, (the 'pothead', the 'speedfreak' and the 'acidhead') is in need of medical and psychiatric or psychological treatment. . . .

On the other hand, the neo-nonconformist who is using drugs but is not sick in the medical or psychiatric sense, may not need treatment. If it seems desirable to bring about a change in his behaviour, only a philosophical and spiritual reorientation, which would have to

touch the cultural roots of his values and existential attitudes, could achieve this goal. (Sec. 355)

In relation to the theme of social upheaval and rejection of tradition (Sec. 352), the same question arises. A historical perspective of the "generation gap" and social upheaval might be useful. Many transitional periods in the history of Western civilization, such as the later Middle Ages, the Industrial Revolution, and the period after the First World War must have been very comparable to the present in terms of the break with past traditions. Were there drug problems at those times?

Greater use should have been made of other empirical types of evidence on motivation. For example, the Foundation's study on the patterns of drug use by the parents of juvenile drug users raises again the question of social pressures which direct individual responses (Smart, Fejer, and Alexander, A.R.F. Substudy 1—7 & Jo & Al—70). The paper by Mauss (*Social Problems* 16: 357, 1969) on the importance of anticipated attendance at university to drug use by high-school students, and the LSD and cannabis user studies by Smart *et al* and by Oki and Sisson, provide other evidence of such factors.

Finally, we believe that the explanation of alcohol and other drug use on the grounds of relief of tension (Sec. 344) is neither as common nor as simple as is stated. Mild euphoria, rather than relief of overt tension or anxiety, is a much more common goal of social use of alcohol. In this context, the holding of a glass and the act of drinking are of great importance, symbolic or otherwise, because the benefits are often perceived by the user long before any pharmacological action is demonstrable. It is also worth noting that no one uses "nicotine," but many people use cigarettes. In other words, the act of smoking is itself important, apart from its function of administering a drug.

Chapter 5—"Present Canadian Policy—The Law." The introduction (Part A) of this chapter points out that law is only one of the social responses to the phenomenon of non-medical drug use, and that "it is far from clear what its relative importance is in the long run. It is, nevertheless, the dominant response at present, and it colours our approach to all the others." (Sec. 357)

Part B begins with a very brief review of the history of Canadian legislative policy. This began in 1908 following Mackenzie King's *Report on the Need for the Suppression of Opium in Canada*. It was originally aimed at Oriental immigrants. The addition of marihuana to this legislation in 1923 did not appear to be based on any scientific evidence. Penalties for trafficking and possession for trafficking were gradually increased down to the Narcotic Control Act of 1961.

It is the view of the Foundation's Research Department that this section should be considerably enlarged, with more detail on the evidence and reasons which were given at each stage in the evolution of the Canadian laws. This would help the public to understand the present situation better, and would be a valuable addition to the educational function of the report.

It is clear from Cook, "Social Background of Narcotics Legislation" (*Addictions*, Vol. 17, No. 2, Summer, 1970, pp. 14-29) that through most of this historical period almost the entire input of information to the legislators came from law-enforcement personnel. Medical and scientific participation in the process was minimal. "The consequences of this enforcement monopoly have been along predictable lines. The traditional police interest in severe penalties has been clearly manifested in the legislative trends mentioned earlier. Harsher penalties, by making the offence more 'serious,' have enhanced the importance of the enforcement job—as well as providing such practical advantages as greater bargaining power in dealing with informers. The enforcement concern with the difficulties of securing evidence and ensuring convic-

tion has been reflected in successive statutory encroachments on traditional legal safeguards.” (Cook, *op. cit.*, p. 20)

Part B also outlines the international conventions which commit participating countries (including Canada) to strict controls, and some of the constitutional issues that are involved within Canada. In summarizing these latter the interim report states:

The federal government controls the criminal law approach to non-medical drug use and the provinces would appear to control the approach of ‘legalization’, involving government monopoly of distribution.

The division of constitutional responsibility with respect to other aspects of the social response to non-medical drug use—in particular, research, education and treatment—also indicates the appropriateness of federal-provincial consultation and cooperation to develop a coordinated national policy. (Sec. 371)

Part C of Chapter 5 summarizes the relevant provisions of the Narcotic Control Act and the Food and Drugs Act and some judicial interpretations. (Secs. 373-383)

Chapter 6—“The Issues—Some Interim Recommendations.” In introducing this chapter the commissioners emphasize two characteristics of the interim report, namely, the preliminary nature of its findings and the selective treatment of the subject. They call attention to the words “problems involved in non-medical drug use” as distinct from the phenomenon of non-medical drug use as such, and raise the question whether this latter is itself a “problem.” In general their answer is:

WHILE WE CANNOT SAY THAT ANY AND ALL NON-MEDICAL USE OF PSYCHOTROPIC DRUGS IS TO BE CONDEMNED IN PRINCIPLE, THE POTENTIAL FOR HARM OF NON-MEDICAL DRUG USE AS A WHOLE IS SUCH THAT IT MUST BE REGARDED, ON BALANCE, AS A PHENOMENON TO BE CONTROLLED. THE EXTENT TO WHICH ANY PARTICULAR DRUG USE IS TO BE DEEMED TO BE UNDESIRABLE WILL DEPEND UPON ITS RELATIVE POTENTIAL FOR HARM, BOTH PERSONAL AND SOCIAL. (Sec. 390)

Beyond this, they suggest that the following are among the important problems to be considered:

- (a) the harm (whether personal or social) produced by certain non-medical drug use;
- (b) the extent and patterns of such use, and in particular its increase among certain age groups in the population;
- (c) the aspects of our personal relations and social conditions today which encourage such use;
- (d) the proliferation and adulteration of drugs;
- (e) the lack of sufficient scientifically valid and accepted information concerning the phenomenon of non-medical drug use;
- (f) the lack of a coordinated and otherwise effective approach to the timely collection and dissemination of such information as does exist, including appropriate drug education programmes;
- (g) our present approach to treatment and the other supportive services required to assist people suffering from the adverse effects of non-medical drug use; and
- (h) the content and application of the criminal law in the field of non-medical drug use. (Sec. 388)

In discussing the general emphasis in the range of possible social responses to the phenomenon of non-medical drug use, the commissioners state:

We believe that this emphasis must shift, as we develop and strengthen the non-coercive aspects of our social response, from a reliance on suppression to a reliance on the wise exercise of freedom of choice. (Sec. 389)

Part B of this chapter deals with proper classification and effects of a more limited number of drugs (cannabis, LSD, and the amphetamines) than were considered in earlier chapters. This selectivity the commissioners justify not on grounds of overall perspective but on grounds that, in terms of short-term public-policy decisions, they call for special comment at this time.

In relation to cannabis, the commissioners observe:

ON THE QUESTION OF LEGAL CLASSIFICATION WE AGREE WITH THE CANADIAN MEDICAL ASSOCIATION'S SUGGESTION THAT IT HAS GREATEST AFFINITY WITH THE RESTRICTED DRUGS IN SCHEDULE J OF PART IV OF THE FOOD AND DRUGS ACT. WE SHALL HAVE MORE TO SAY ON THIS POINT IN OUR INTERIM RECOMMENDATIONS FOR CHANGES IN THE LAW. (Sec. 395)

The Foundation's scientists see no need to question this classi-

fication of cannabis as a hallucinogen, if considerations of dosage are kept in mind. In low doses (e.g., the usual use of marihuana) it is a mild intoxicant, and in high doses it is a hallucinogen (cf. Isbell *et al.*, *Psychopharmacologia* 11:184, 1967). The term "cannabis" applies to a large variety of preparations, varying widely in potency and in pattern of use. A simple parallel can be drawn with alcohol, which is found in forms ranging from near-beer to over-proof spirit, by pointing out that alcohol in low doses is a mild intoxicant and in high doses a respiratory depressant. In general, the report does not give sufficient attention to the effects of high doses of cannabis, especially in view of the increasing availability of hashish.

The report then refers to the short-term physical effects, the short-term psychological effects, and the effect on cognitive functions and psychomotor abilities.

Regarding the first, it states:

After centuries of use in a great number of countries, and extensive opportunities for clinical observation, the short-term physical effects of cannabis which have been brought to the attention of trained observers and mankind in general are relatively insignificant. (Sec. 396)

Regarding the short-term psychological effects (Sec. 397), the commissioners refer to cannabis as, like alcohol, an intoxicant, euphoriant, relaxant, a reducer of social inhibitions, producing a more introspective, self-absorbed mood than alcohol. "Bad trips" and psychotic reactions are rare but have occasionally been reported.

Regarding the third type of effect—cognitive and psychomotor—the report states:

EXISTING SCIENTIFIC KNOWLEDGE AND OPINION CONCERNING THE EFFECTS OF CANNABIS ON COGNITIVE FUNCTIONS AND PSYCHOMOTOR ABILITIES IS NOT OF SUCH AN ORDER AS CAN BE RELIED ON AT THIS TIME FOR PURPOSES OF PUBLIC POLICY DECISION-MAKING. (Sec. 398)

Regarding long-term effects, the report states:

There is hardly any reliable information applicable to North American conditions concerning the long-term effects of cannabis. Because

of the likelihood of significant differences in the many variables determining drug effects (physiological and psychological condition of subjects; conditions of nutrition, sanitation, climate and the like; potency, dose levels and frequency of use, as well as other drug use) the results of studies in other countries are of highly questionable applicability to North American conditions. Much further investigation is required to determine the extent to which the experience in other countries with cannabis might be utilized by properly controlled retrospective studies to yield results that would have relevance for North America. (Sec. 399)

We agree with the Commission's views as to the need for research on the long-term effects of cannabis use. Brill has pointed out that the recognition of patterns of dependence on other drugs has invariably come after a lengthy period of use in the general population, rather than as a result of initial screening in laboratory studies ("Drugs and Youth," in Wittenborn *et al.*, eds., *Proceedings of Rutgers Symposium on Drug Abuse*, 1969, Chap. 2). Similarly, the recognition of physical damage caused by such "safe" drugs as thalidomide, tolbutamide, phenacetin or tobacco, has required many years of observation. It would probably be wise to emphasize (Sec. 419) that it *will be* (not "may well be") "a decade or more before we have adequate information" on long-term effects.

In this connection it is worth pointing out that a physical examination conducted at a single point in time, even with a large number of subjects, is a notoriously unreliable method of discovering the incidence of physical damage resulting from use of a drug. If a drug-induced disease is fatal in a relatively short time (e.g., lung cancer, or alcoholic cirrhosis of the liver), very few cases will be found, even among heavy users, at a single examination. There is a 50% probability that a *single* examination of a random group of 1,000 heavy smokers between the ages of 40 and 50 years would turn up *no* cases of lung cancer. The only reliable ways of determining damage in humans due to long-term drug use are mortality studies using long follow-up and large samples, or

matched comparisons of users and non-users with samples about ten times as large as that in the Chopra study.

Regarding LSD, the report states:

LSD belongs clearly in the category of *psychedelic-hallucinogen* drugs. (Sec. 401) . . . LSD, like all drugs classified in the *psychedelic-hallucinogenic* category, disorganizes normal mental activity. (Sec. 403)

Physical effects of the drug are less pronounced and occur mainly in the early phases of an LSD reaction, when the drug produces a stimulating effect on many automatic nervous functions. . . .

A few years ago, a possible adverse effect of LSD on human chromosomes was described. Studies to test this finding have yielded conflicting results. . . . However, due to the seriousness of the possible consequences if such damage should occur, research in this area must continue. . . . Furthermore, there is evidence that large doses of LSD, injected during pregnancy can produce deformities in the offspring in certain strains of rodent but not in others. Although such effects have not been clearly demonstrated in humans the possibility must be given careful consideration. (Sec. 402)

Regarding long-term effects:

Statistical evidence for the incidence of lasting effects of self-administered LSD on the personality structure is still very sketchy, but there is perhaps more clinical support for the unfavorable than for the favorable changes. . . .

On balance, it may be concluded that the significant incidence of very serious unfavorable effects, coupled with the impossibility of predicting or effectively controlling the effects of self-administered LSD, constitute, at present, serious potential dangers. (Sec. 404)

The remainder of Part B of this chapter deals with submissions to the Commission about multiple drug use, progression and relationship of drug use to crime. On these matters the report makes the following two statements:

WE FEEL WE MUST TAKE SERIOUSLY THE FACT OF MULTIPLE DRUG USE AND FURTHER INVESTIGATE THE CONTENTION OF DRUG CONTAGION OR DRUG PROGRESSION. (Sec. 411)

THE COMMISSION INTENDS TO INVESTIGATE FURTHER THE ALLEGATIONS OF RELATIONSHIP BETWEEN DRUG USE AND OTHER CRIMINAL ACTIVITY. (Sec. 412)

Parts C and D review briefly the matters covered in

Chapters 3 and 4 and note the fact that a major epidemiological survey is now being carried out on the Commission's behalf.

The Foundation's research staff are inclined to question the Commission's conviction that "the vast majority [of drug users] fall within the normal range of psychological functioning" (Sec. 414). Perhaps this is true, but some evidence should be presented to support the statement. The point is of some importance, because all the available studies of drug users have indicated a high proportion of psychopathology. Admittedly, the selection of subjects in these studies is such that the populations involved cannot be taken to represent the whole population of drug users. Nevertheless this evidence is on record, and any different conclusion should be backed by new evidence. Also, the Commission's statement is hard to reconcile with the general theoretical framework derived from the field of alcohol studies, which would suggest that the proportion of psychologically "vulnerable" subjects is greater among heavy users, and among users of socially disapproved substances.

Regarding amphetamines, in Sections 407-409 the report goes into considerable detail as to the variety of short-term and long-term undesirable effects of moderate and large doses of this type of drug. These are mostly well known. However, the sharp differentiation made by the commissioners between low-dose oral amphetamine use and high-dose intravenous use is not viewed by the Foundation as entirely valid. Table 8 of O. J. Kalant's *The Amphetamines: Toxicity and Addiction* (Brookside Monograph No. 5—Toronto: University of Toronto Press, 1966) shows many instances of oral doses of several hundred milligrams daily, and even up to 1250 mg/day. The important differentiating feature is in fact the intravenous route rather than the size of the dose. Further, the phenomenon is not new—merely new in North America. The Japanese experience was largely with intravenous use (see Chapter 5 of the Kalant monograph), and the table cited

above gives sporadic instances in other countries. The toxic effects of high-dose use are identical, whether by oral or by intravenous use; only the acute onset (and hence the risk of dependence) are exaggerated by intravenous injection.

In view of popular folklore, the following additional comment by the commissioners should be noted:

To this date there is little evidence that the slogan 'speed kills' has concrete applicability. The disastrous effects of massive doses of 'speed' on the user's physical and mental health, appearance and behaviour either cause him to quit using the drug on his own initiative, or to be hospitalized for physical or mental breakdown, or to be arrested for delinquent behavior, long before his drug habit has killed him. (Sec. 409)

Part E of this chapter deals with the Commission's interim proposals for social response under the headings of (1) Research, Information and Education, (2) The Law, (3) Treatment and Supportive Services, and (4) Prescribing Practices and Controls.

1. Research, Information and Education

The interim report comments on the state of research as follows:

Until recently, research on certain of the psychotropic drugs, such as cannabis, has been impeded or discouraged by several factors: the lack of clearly established medical uses for the drug, the lack of previous wide-spread non-medical use in the Western World, the illegal character of the drugs and the reluctance of government agencies to authorize such research. Although it has been possible for governments, under the terms of the United Nations Single Convention on Narcotic Drugs, to authorize the possession of cannabis for medical or scientific purposes, there is reason to believe that such steps as have been taken nationally, and internationally, have not substantially encouraged such research. Public policy on this point would appear to have been heavily influenced by the attitude of law enforcement authorities rather than by scientific advisors. (Sec. 416)

The Foundation in Ontario has only recently begun to receive a reasonable amount of cooperation from federal authorities in regard to authorizing possession of controlled substances for research, and the governmental procedures in-

volved are still slow and complicated. In relation to this type of problem:

THE COMMISSION INVITES SCIENTISTS INTERESTED IN RESEARCH ON PSYCHOTROPIC SUBSTANCES TO COMMENT ON SUCH PROTOCOLS AND REGULATIONS WHICH MAY AFFECT THEIR RESEARCH, THEIR PLANNING OF NEW PROJECTS AND THE PUBLIC COMMUNICATION OF RESULTS. (Sec. 416)

IN OUR OPINION, RESEARCH INTO THE EFFECTS, THE EXTENT, THE CAUSES, AND THE PREVENTION AND TREATMENT OF DANGEROUS ASPECTS OF NON-MEDICAL DRUG USE SHOULD BE PURSUED WITH ALL POSSIBLE VIGOUR IN AN ENVIRONMENT OF FLEXIBILITY AND FREEDOM. (Sec. 417)

THE COMMISSION INTENDS TO MAINTAIN CLOSE CONTACT WITH, AND CRITICALLY EVALUATE, RESEARCH IN THESE AREAS AND TO REPORT THEREON. (Sec. 418)

As a result of ongoing research in North America and abroad, it appears that by the spring of 1971 we may have a good deal more information on the chemistry, basic pharmacology and toxicology of cannabis in animals. A few human studies may be conducted which might provide new data on the short term effects of cannabis on driving skills, and on some elementary cognitive, perceptual and psychomotor functions. . . .

On the other hand, it may well be a decade or more before we have adequate information on a number of possibly important issues: long-term physiological effects of cannabis on respiratory function and on the central nervous system; the possibility of effects on chromosomes and developing offspring; long term psychological effects of social and psychiatric importance; the frequency and characteristics of potential patterns of moderate and extreme cannabis use in North America. (Sec. 419)

WE RECOMMEND THAT THE FEDERAL GOVERNMENT ACTIVELY ENCOURAGE RESEARCH INTO THE PHENOMENON OF NON-MEDICAL DRUG USE, AND IN PARTICULAR, RESEARCH INTO THE EFFECTS OF PSYCHOTROPIC DRUGS AND SUBSTANCES ON HUMANS. THE GOVERNMENT SHOULD NOT ONLY GIVE ITS APPROVAL TO SUCH RESEARCH, UPON REASONABLE CONDITIONS, BUT SHOULD ENCOURAGE, SOLICIT AND ASSIST IT WITH FINANCIAL SUPPORT IN THE FORM OF RESEARCH GRANTS. . . .

IT IS RECOMMENDED THAT THE FEDERAL GOVERNMENT MAKE AVAILABLE TO RESEARCHERS, AS SOON AS POSSIBLE, STANDARD PREPARATIONS OF CANNABIS AND PURE CANNABINOLS. WHILE COOPERATION WITH SCIENTISTS AND GOVERNMENT AUTHORITIES OF OTHER COUNTRIES WOULD CLEARLY BE ADVISABLE, IT IS RECOMMENDED THAT CANADA TAKE

THE INITIATIVE TO DEVELOP A SEPARATE AND INDEPENDENT RESEARCH PROGRAM AT THIS TIME. UNDER THE PRESENT CIRCUMSTANCES THIS CALLS FOR GOVERNMENT CONTROLLED CULTIVATION, PRODUCTION AND STANDARDIZATION OF CANNABIS AND CANNABINOLS IN CANADA.

IT IS FURTHER RECOMMENDED THAT EXPERIMENTAL INVESTIGATION INTO THE EFFECTS OF CANNABIS ON HUMANS, AS WELL AS ANIMAL AND BASIC CHEMICAL RESEARCH, BE ENCOURAGED AND FINANCIALLY SUPPORTED BY THE FEDERAL GOVERNMENT IMMEDIATELY. ALTHOUGH A CERTAIN AMOUNT OF THIS WORK MIGHT BE CONDUCTED BY GOVERNMENTAL PERSONNEL, IT IS RECOMMENDED THAT INDEPENDENT SCIENTISTS (IN UNIVERSITY LABORATORIES, FOR EXAMPLE) BE SIGNIFICANTLY INVOLVED IN THE OVERALL RESEARCH EFFORT. APPLICATIONS TO THE FEDERAL GOVERNMENT FOR RESEARCH AUTHORIZATION SHOULD BE EVALUATED BY INDEPENDENT SCIENTISTS AS WELL AS CIVIL SERVANTS, AND THE BASIS FOR GOVERNMENTAL DECISIONS MADE PUBLIC. (Sec. 420)

Several references are made in the interim report to the results of laboratory analyses made by the Foundation of "street" samples of various drugs. This work has had to be severely curtailed owing to the lack of legal immunity for those involved in bringing in such samples. Such laboratory analyses can perform several service functions, both for clinical and educational personnel and for defence counsel. (The latter currently have no access to the samples analysed on behalf of the prosecution against their clients or to the laboratories used, hence no means of challenging the competence of the analysis being used against them.)

The Foundation does not wish its own research laboratories to be overloaded with such service work, and therefore strongly supports the following proposals made by the Commission:

WE RECOMMEND THAT THE FEDERAL GOVERNMENT ACTIVELY INVESTIGATE THE ESTABLISHMENT OF REGIONAL DRUG ANALYTICAL LABORATORIES AT STRATEGIC POINTS ACROSS THE COUNTRY. There is no reason to believe, however, that the problems of staffing and financing, to assure an adequate service for quantitative as well as qualitative analysis, might have been underestimated by persons who have urged the establishment of such services. Such laboratories should not be connected with government or law enforcement, and should

be free from day-to-day interference by public authorities. It is sufficient for the government to retain ultimate control through the necessity of its approval which may be withdrawn for cause. The Commission will also study the matter. . . . IN THE MEANTIME, WE WOULD RECOMMEND THAT, PENDING OUR FINAL REPORT, ARRANGEMENTS BE MADE WHERE POSSIBLE THROUGH UNIVERSITIES AND OTHER AGENCIES FOR THE PROVISION OF LABORATORY FACILITIES TO RENDER SUCH SERVICE. (Sec. 424)

In support of this recommendation, the Commission outlines the pro and con arguments it has received as follows:

It is feared by some that such facilities and information may encourage the use of drugs by advertising their availability and reducing dangers. It has been further suggested that distributors will take advantage of these facilities to have their products tested and, as it were, approved. Whatever force there may be in these arguments, they are outweighed, it would seem, by the necessity of a thorough and effective commitment to know as much as possible about what is happening in non-medical drug use and to make such knowledge available for the benefit of those who may be prudent enough to be guided by it. We have more to fear from willful ignorance than we do from knowledge in this field. In this risk-taking generation, young people are going to continue to experiment with drugs, regardless of what we do. It is better that they should see the whole sordid picture of fraud, adulteration and crass commercial exploitation. In its own pretensions to idealism, the drug culture tends to conceal from itself the extent to which it has become infected with many of the evils which it deplors in the established society. Sample analysis and wide dissemination of the results can only serve in the long run to de-glamourize drugs and drug-taking. (Sec. 424)

In passing it should be noted that youthful risk-taking is not something unique to the present generation. The Children's Crusade is a remarkable example, as was the social upheaval after the First World War. There is a clear need for a historical perspective on the factors which we tend to accept, perhaps too easily, as being responsible for the heavy use of drugs today.

Passing on to the area of information, the Commission notes the variety of conflicting opinion it received on the role and performance of the mass media in relation to the pheno-

menon of non-medical drug use. The only recommendation put forth was:

WE RECOMMEND THAT THE FEDERAL GOVERNMENT KEEP THE MEDIA AS FULLY INFORMED AS POSSIBLE OF ITS OWN INFORMATION ABOUT NON-MEDICAL DRUG USE. (Sec. 426)

... The manner in which the media select, edit, and present drug items deserves much more attention by the Commission.

A somewhat related subject which the interim report does not discuss to any great extent is the advertising bombardment—through all media, but especially radio and television—which promotes drug use of various kinds. The interim report does refer to “the capacity of this society to learn to live wisely in a world in which chemicals and chemical change will increasingly be significant” (Sec. 427), and it would seem appropriate at that point to introduce some questions about the nature and extent of advertising for fast, faster, fastest relief from every kind of ache and pain and minor discomfort that assails people everywhere, every day. Advertising in the mass media must be investigated as a significant influence in our society’s acceptance of chemical solutions to life problems. It is also clear that television and radio advertising lies within federal jurisdiction under the Canadian Radio and Television Commission.

Regarding information and education in general, the Commission states its belief that the purpose of drug education “must be to provide the basis for informed and wise personal choice. The ultimate effect that we would hope for is reasonable control and even overall reduction in the non-medical use of drugs.” (Sec. 427) It goes on also to say:

Drug education should be merely an aspect of general education and should be directed to the same general objective: the kind of understanding that will permit an individual to live wisely, in harmony with himself and his environment. (Sec. 427)

Both of these principles have long been fundamental to the Foundation’s own educational programs and those which

have been worked out, in collaboration with the Foundation, by the Ontario Department of Education. . . .

The Commission, although it has made some recommendations in the educational area, is only beginning, as it enters its year of developing social responses, to go deeply into what is involved in education. In recent discussions with the Commission's staff, it has been suggested that there are really two different components in the drug educational process: (1) information—providing the best available hard data about drugs; and (2) education—communicating an awareness of alternatives to drug-using behavior and preparing people to make their own appropriate and responsible choices.

With respect to the first component, provision of drug information, the interim report notes:

There is general agreement that we lack sufficient reliable information to make sound social policy decisions and wise personal choices in relation to non-medical drug use. (Sec. 415)

Having cited the lack of sufficient reliable information and thus underlined the prime need for research into all aspects of non-medical drug use, the interim report urges an information program involving selection, system, purpose, and perspective—given the basic data to be conveyed. In this connection, it mentions a number of valid points to guide such an information program. Among these points are the following:

There must be some source of disinterested and authoritative opinion to which those seeking information can turn for guidance to determine what can be relied upon for public policy and drug education. This system must be one which commands widespread confidence because of its independence from political pressures, its competence, and its reputation for objective evaluation. (Sec. 422)

Not only is there a problem of timeliness of information in a rapidly changing scene, but there is also a problem of the credibility of the sources of information. . . . There is evidence that young people lack confidence in certain sources of information. (Sec. 425)

There has been a general insistence that any drug education programme must provide a full disclosure of all facts concerning the

drugs, whether these be positive or unfavourable. There has also been a general agreement by those to whom we have spoken that the *whole truth* be told as far as is humanly possible. We have been advised, particularly by the young, that education about drugs will be ineffectual unless moralizing and patronizing attitudes are changed. The facts, we have been told, must be presented with a proper sense of proportion and perspective so that the overall impression conveyed is truthful and realistic. (Sec. 427)

The conclusion we draw from the testimony we have heard is that it is a grave error to indulge in deliberate distortion or exaggeration concerning the alleged dangers of a particular drug, or to base a programme of drug education upon a strategy of fear. It is no use playing 'chicken' with young people; in nine cases out of ten they will accept the challenge. (Sec. 427)

The commissioners noted, however, that "there is reason to believe that many young people have been deterred from the use of LSD and the amphetamines by the presumptive evidence of their potential for harm. In other words, despite their spirit of risk-taking, they are responsive to serious evidence of the probability of harm." (Sec. 427)

They were particularly heartened by evidence that "young people are concerned to preserve their own capacity to have healthy children and not to visit the consequences of their own risk-taking upon another generation." (Sec. 427)

The interim report suggests that the collection and evaluation of information is really a separate process from its utilization "and the two are not necessarily compatible or capable of being carried out by the same agencies." (Sec. 428)

On the surface this appears contrary to the 20 years' experience of the Addiction Research Foundation of Ontario, which has shown that it is precisely the scientific approach of the A.R.F. Research Division that has lent believability to the products of the Education Division. Further, the interim report states that "the development of effective educational devices and techniques calls for a variety of other professional skills that would not be involved in scientific research and evaluation" (Sec. 428), thereby entirely overlooking the

importance of involving scientific research and evaluation skills in assessing the effects of education procedures and feeding back modifying data into the system.

It is a considerable jump from the provision of information to the changing of behavior. As noted above, a system can be set up to find, assess, select, package, and deliver data in a variety of forms—bearing in mind the guidelines mentioned in the interim report as well as others. All of these matters have to do with the first—and easier—information component in the process of drug education defined earlier. The second part is preparing—and trusting—people to make appropriate and responsible choices with respect to non-medical drug use and other forms of behavior. The latter is not a job for a government information agency, even though whoever does it may make use of some material from such an agency from time to time.

This second phase, which is truly education as distinct from information-giving, devolves upon good teachers, whether they be in the school system, or in the home, or elsewhere in the community. Such teachers are not necessarily fountain-heads of drug lore, but rather they are sensitive human beings capable of true give-and-take communication; and they are also sufficiently mature and comfortable in their environment so they do not have to build themselves up at the expense of other people.

The interim report observes (Sec. 427) that “opinion differs as to whether drug education should be a separate course taught by specialists or whether it should be taught more pervasively as part of the general health and physical education programme.” It sees this as a problem of reconciling a need for some special training with the desirability of having the subject taught as other than a specialty, and concludes:

ON BALANCE, WE BELIEVE THAT THERE WILL HAVE TO BE SOME DEGREE OF SPECIALIZATION IF DRUG EDUCATION IS TO COMMAND THE RESPECT OF YOUNG PEOPLE. (Sec. 427)

Such specialization is seen in part as enabling such teachers to equal the drug-knowledge sophistication of their pupils, which thought leads to the credibility advantage that young people themselves might be presumed to have as teachers. The Commission therefore says:

WE BELIEVE THAT SERIOUS CONSIDERATION SHOULD BE GIVEN TO TRAINING YOUNG PEOPLE FOR PARTICIPATION IN DRUG EDUCATION. (Sec. 427)

Although there is merit in both of these suggestions, neither envisages the larger responsibility of the teacher as a mentor about life rather than merely about drugs. Mature teachers (in outlook, not necessarily in years) have shown that they can guide drug-preventing classroom discussions with little or no reference to drugs *per se*. (One of the best filmstrips now available in this field, *Let's Talk About Drugs*, spends most of its time asking questions about people and about "What do you want to do with your life?")

In reference to the use of young people for participation in drug education, it is recognized that there are both advantages and disadvantages attending the process. Freedman, Stolow, and Lewis reported recently on their observations of this in a Massachusetts regional high school.* They found that most of the discussion was about drugs with little reference to motivations for use; and the youthful discussion leaders tended to indicate acceptance of some drug use, setting a tone which "may have inhibited participation on the part of many students who held absolutist anti-drug positions." In a follow-up questionnaire some students said they were puzzled by the paradox of having people who still took drugs talking to teenagers about drug use and abuse, and some asked for exposure to more than one discussion leader's opinions. (They suggested hearing from psychologists, former drug addicts,

* Freedman, M., Stolow, A., and Lewis, D. C., "Utilizing Drug-Experienced Youth in Drug Education Programs," *National Association of Secondary School Principals Bulletin*, Sept., 1969.

medical researchers, lawyers, and policemen.) Members of the school faculty said they would have liked the discussion leaders to focus on options other than drug-taking for handling personal problems. In only half of the sessions was the use of alcohol and tobacco mentioned as a part of the overall drug picture, despite survey findings that these two substances are much more widely used by young people than all the other drugs. The authors conclude that participation of drug-experienced young people is a viable technique, but caution that those organizing such programs should carefully define the function of outside experts as a part of an on-going educational process.

In discussing "the need for a nationally coordinated system of information and education" (Sec. 428), the interim report becomes somewhat involved in what is admittedly an incomplete consideration of various levels of governmental and non-governmental service. As they say:

We are not yet able to perceive the precise outlines, much less the detail of the system which should be established, but WE STRONGLY RECOMMEND THAT THE DEVELOPMENT OF AN APPROPRIATE SYSTEM BE GIVEN HIGH PRIORITY AS A MATTER OF FEDERAL-PROVINCIAL COOPERATION. (Sec. 428)

They then suggest further study of the Canadian Medical Association's proposal for formation of regional, multi-disciplinary, non-governmental teams. The report gives qualified approval to this suggestion (Sec. 428) but expresses concern that such regional teams should not become filled up by established professional figures and leading citizens while lacking adequate representation of young people. The CMA system contemplates some kind of federal system for its regional teams, and here the commissioners become concerned about what government's role will be, in that they state:

IN OUR OPINION, THE SYSTEM CONTEMPLATED BY THE CANADIAN MEDICAL ASSOCIATION DOES NOT EXCLUDE AN IMPORTANT ROLE FOR FEDERAL GOVERNMENT INITIATIVE. WE BELIEVE THAT THE NEED FOR AN

ACCEPTABLE SYSTEM OF EVALUATION AND AUTHENTICATION ON WHICH THE ENTIRE COUNTRY CAN RELY CALLS FOR THE ESTABLISHMENT OF A NATIONAL AGENCY TO STIMULATE AND COORDINATE RESEARCH, AND TO COLLECT, EVALUATE AND DISSEMINATE THE RESULTING DATA. . . .

WE BELIEVE THAT THE STIMULATION AND COORDINATION OF RESEARCH AND THE EVALUATION OF DATA ARE BEST CARRIED OUT BY AN INDEPENDENT AGENCY THAT HAS NO CONNECTIONS WITH THE RESPONSIBILITY FOR LAW ENFORCEMENT. . . .

IT IS PROBABLE THAT IN ADDITION TO THE NATIONAL SCIENTIFIC AGENCY THERE SHOULD BE A FEDERAL-PROVINCIAL INSTITUTION FOR THE DEVELOPMENT OF DRUG EDUCATION MATERIALS. (Sec. 428)

At this point there seems to be some need for clarification of goals before the establishment of too much institutional machinery to achieve such goals.

2. The Law

After briefly reviewing the relationship of law to its terms of reference, and the international and constitutional framework of present law related to non-medical drug use, the commissioners present arguments based on John Stuart Mill, H. L. A. Hart, and Lord Devlin, which are relevant to whether or not non-medical drug use ought to be restricted by law.

Based on this discussion of legal philosophy, the interim report concludes in favor of the following principles:

The state has a responsibility to restrict the *availability* of harmful substances. (Sec. 442)

Society has a right to use the criminal law to protect itself from harm which truly threatens its existence as a politically, socially and economically viable order. (Sec. 443)

The criminal law should not be used for the enforcement of morality without regard to potential for harm. (Sec. 444)

In Sections 447 and 448 the Commission states:

AT THE PRESENT TIME WE ARE NOT CONVINCED OF THE NECESSARY RELATIONSHIP BETWEEN THE OFFENCE OF SIMPLE POSSESSION AND TRAFFICKING, OR OF THE NECESSITY OF SUCH AN OFFENCE FOR EFFECTIVE LAW ENFORCEMENT AGAINST TRAFFICKING. WE DO FEEL, HOWEVER, THAT FURTHER STUDY AND CONSIDERATION MUST BE GIVEN TO THE CONTENTION OF THE LAW ENFORCEMENT AUTHORITIES ON THIS

POINT, AND FOR THIS REASON WE ARE NOT PREPARED AT THIS TIME TO RECOMMEND THE TOTAL ELIMINATION OF THE OFFENCE OF SIMPLE POSSESSION IN RESPECT OF NON-MEDICAL DRUG USE. (Sec. 447)

IN EFFECT, WHILE WE FEEL THE OFFENCE OF SIMPLE POSSESSION SHOULD BE RETAINED ON THE STATUTE BOOK, PENDING FURTHER INVESTIGATION AND ANALYSIS, WHICH WE HOPE TO CARRY OUT IN THE ENSUING YEAR, ITS IMPACT ON THE INDIVIDUAL SHOULD BE REDUCED AS MUCH AS POSSIBLE. (Sec. 448)

Clearly the Commission believes that if trafficking can be controlled without availability of the offence of simple possession, then the latter offence, which they find philosophically undesirable, becomes also no longer a necessary evil. While on the surface this challenges the law-enforcement authorities to prove their traditional point, it could also be approached as a challenge to the law-enforcement people, and perhaps also the public-health people, to come up with some innovative approaches to the problem of controlling trafficking.

WE INTEND DURING THE ENSUING YEAR TO ATTEMPT TO DETERMINE THE RELATIVE COST IN ACTUAL DOLLARS AND ALLOCATION OF TIME OF THE ENFORCEMENT OF THE DRUG LAWS, BUT IT IS OUR INITIAL IMPRESSION FROM OUR OBSERVATIONS SO FAR THAT IT IS OUT OF ALL PROPORTION TO THE RELATIVE EFFECTIVENESS OF THE LAW. (Sec. 450)

The contention at the end of this proposal would appear to be unprovable, since there is no recognized scale by which a given degree of effectiveness of any law can be given a dollar value. The cost of law enforcement would probably not be appreciably reduced if the present law were not enforced, because the money would be spent in other ways by the enforcement agencies. Fairness and credibility of the law, dealt with elsewhere in Section 450 and also in 451 and 452, are much better arguments.

What evidence supports the contention in Section 451 that the present law has little deterrent effect on the use of cannabis and other drugs? How can one tell what the extent of use would now be if the law did not exist? Despite the numerous assertions that prohibition of alcohol failed, it should not be forgotten that during the prohibition period the cirrhosis

death rate and other indices of alcoholism fell to their lowest values during this century. The question of success or failure of a law has meaning only with respect to the purposes or intentions of that law. If the purpose of prohibition was to *reduce* the consumption of alcohol, then it was probably a success. A reasonable question would be: Was this success worth the price which was paid for it? This becomes clearly a question of values, but not of fact.

In Section 455 we come to the Commission's most significant interim recommendation:

THE COMMISSION IS OF THE OPINION THAT NO ONE SHOULD BE LIABLE TO IMPRISONMENT FOR SIMPLE POSSESSION OF A PSYCHOTROPIC DRUG FOR NON-MEDICAL PURPOSES. . . . ACCORDINGLY, THE COMMISSION RECOMMENDS AS AN INTERIM MEASURE, PENDING ITS FINAL REPORT, THAT THE NARCOTIC CONTROL ACT AND THE FOOD AND DRUGS ACT BE AMENDED TO MAKE THE OFFENCE OF SIMPLE POSSESSION UNDER THESE ACTS PUNISHABLE UPON SUMMARY CONVICTION BY A FINE NOT EXCEEDING A REASONABLE AMOUNT. THE COMMISSION SUGGESTS A MAXIMUM FINE OF \$100. . . .

THE COMMISSION ALSO RECOMMENDS THAT THE POWER CONFERRED BY SECTION 694 (2) OF THE CRIMINAL CODE TO IMPOSE IMPRISONMENT IN DEFAULT OF PAYMENT OF A FINE SHOULD NOT BE EXERCISABLE IN RESPECT OF OFFENCES OF SIMPLE POSSESSION OF PSYCHOTROPIC DRUGS. IN SUCH CASES, THE CROWN SHOULD RELY ON CIVIL PROCEEDINGS TO RECOVER PAYMENT.

THE COMMISSION WOULD FURTHER RECOMMEND THAT THE POLICE, PROSECUTORS AND COURTS EXERCISE THE DISCRETION ENTRUSTED TO THEM AT VARIOUS STAGES OF THE CRIMINAL LAW PROCESS SO AS TO MINIMIZE THE IMPACT OF THE CRIMINAL LAW UPON THE SIMPLE POSSESSOR OF PSYCHOTROPIC DRUGS, PENDING DECISION AS TO THE WHOLE FUTURE OF POSSESSIONAL OFFENCES IN THIS FIELD.

In broad principle, the Foundation sees these as changes in the right direction—although there is room for much discussion as to whether the fines proposed are too high or too low, how they should be collected, whether some drugs should still be excluded from such changes, etc. But the principle of keeping drug users out of prison is one we cannot quarrel with. For some years the severity of sentences available for simple

possession, particularly of marihuana, has been questioned in various public statements by the Foundation. It has been evident to us that educational efforts in this field are impeded by the widespread attitude that such laws are unjust, and that clinical treatment of persons dependent on drugs is often interrupted and seldom helped by incarceration.

The Commission's stated ideal that no one should be imprisoned for simply possessing drugs should presumably apply to heroin and other drugs, as well as to cannabis. In Section 383 (at the top of p. 399) it is pointed out that last year's amendments to the laws concerning simple possession apply to heroin as much as to other drugs covered by the Narcotic Control Act. The Commission's recommendation that simple possession be punishable only by a fine of up to \$100 is simply a further reduction of penalties for possession of the same psychotropic drugs, including the opiates. It seems clear that many more people are at legal risk in relation to cannabis than to opiates; but nothing in the report, or in our own knowledge, warrants a fundamentally different view of the nature of different types of drug dependence. Failure to recognize this might lay the Commission open to the accusation of being more concerned about the safety of the children of middle-class families than about the welfare of lower-class victims of narcotic and other drug dependence.

However, the impact of this recommendation is greatly reduced by the fact that Chapters 2 and 3 devote as much space to cannabis and LSD as to all other drugs together. Also, considerations of political feasibility might mean that insistence on a complete rationalization of all drug laws could sacrifice any hope of a partial change.

Therefore we would suggest that the Commission should set out clearly its distinction between what it considers an ideal social response to the whole range of drug problems, based on facts as far as we know or believe them to be, and what it considers an optimal solution in relation to existing social and political considerations. It is obvious that the feasi-

bility of any specific proposal may change with time, as the attitudes of society change. The report of the Commission will probably be an important factor in bringing about such changes. Therefore we would suggest that the question of feasibility might be handled by assigning priorities to the various components of the ideal solution: to indicate which might be implemented at once, which might be considered in, for example, five to ten years' time, and which might have to be left for some indefinite time in the future. The reasons could then be given frankly for the selection of these priorities.

It would be desirable to explain more fully how a system of fines for the offence of possession of drugs would be made to work without the back-up threat of incarceration for non-payment. Some people have taken "civil proceedings" (Sec. 455) to mean "civil litigation," and are skeptical of its feasibility.

From a health viewpoint there are some other important implications of reducing (or eliminating) penalties for simple possession which have not been stressed by the Commission. These relate to the A.R.F. studies on frequency distribution of alcohol consumption, noted above in connection with Chapter 3. The description of drug use contained in the whole interim report, as well as the recommendations in this chapter, all apply to the situation indicated by estimates of present use. The recommendations for a lightening of the penalties for possession, and re-definition of the offence of trafficking in cannabis, are likely to favor attitudes leading to a greater degree of acceptance, and greater use, of cannabis and other drugs. We feel that this is likely to increase the number of heavy users, and hence the total potential hazard to society. This point should be made clear in the discussion of the recommendations. In addition, we consider it extremely important that a serious attempt be made, in advance of any change in the law, to set up mechanisms for evaluating the consequences of adoption of these recommendations. This

would be particularly necessary if the recommendation for abolition of criminal records were adopted, since the loss of these records would seriously hamper much of the epidemiological and other necessary drug research.

Given acceptance of the Commission's call for a shift towards reliance on the wise exercise of freedom of choice, these comments point up a need for perhaps a stage-by-stage relaxation of repressive laws over a period of years, with advance preparation for measurement and evaluation of effects. During the same period there could be an offsetting escalation of appropriate compensatory measures in such fields as drug-control administration, health services and education.

If criminal law is withdrawn from this field, most of the needed compensatory measures will fall under provincial jurisdiction, although presumably some federal assistance could still be involved. In any event, federal-provincial planning will be involved if the overall problem is to be tackled on an adequately comprehensive basis. . . .

Drug-control administration is right now almost wholly a federal area; but this may not necessarily continue to be so, apart from the import-export area. Provincial public-health authorities need to plan ways in which they can fit into this.

It is by no means inconceivable that at some future date the provinces would find themselves in the marihuana business. This might not be a desirable state of affairs; but some study should be given to what various alternative mechanisms could be, and how they might function.

We can anticipate that a healthy pharmaceutical industry (aided by enthusiastic amateur chemists and botanists) will in future be able to provide more and more rather than fewer chemical aids for changing man's mood or mental function. Organized society's problem is to contain this sort of evolution in such a way as to maximize the benefits and minimize the problems. In order to do so we must become willing to at least experiment with ways of adapting to change which hold

forth any reasonable prospect of being more successful than the ways inherited from earlier times when circumstances were different.

The interim report also makes the following recommendations relative to specific drugs:

Amphetamines, Barbiturates:

AT THE PRESENT TIME, WE ADVOCATE CLOSER CONTROLS ON THE AVAILABILITY OF THESE DRUGS, INCLUDING CONTROLS ON PRODUCTION, IMPORTATION AND PRESCRIPTION. (Sec. 458)

Marihuana or Cannabis:

FOR THE FOLLOWING REASONS WE ARE NOT PREPARED AT THIS TIME TO RECOMMEND THE LEGALIZATION OF CANNABIS:

- (1) FIRST, IT IS OUR IMPRESSION THAT THERE HAS NOT YET BEEN ENOUGH INFORMED PUBLIC DEBATE. CERTAINLY THERE HAS BEEN MUCH DEBATE, BUT TOO OFTEN IT HAS BEEN BASED ON HEARSAY, MYTH AND ILL-INFORMED OPINION ABOUT THE EFFECTS OF THE DRUG. WE HOPE THAT THIS REPORT WILL ASSIST IN PROVIDING A BASIS FOR INFORMED DEBATE NOT ONLY AS TO THE EFFECTS, BUT AS TO OTHER ISSUES, INCLUDING THE EXTENT TO WHICH SCIENCE IS CAPABLE OF PROVIDING A BASIS FOR PUBLIC POLICY DECISION ON THIS QUESTION.
- (2) THERE IS A BODY OF FURTHER SCIENTIFIC INFORMATION, IMPORTANT FOR LEGISLATION, THAT CAN BE GATHERED BY SHORT TERM RESEARCH—FOR EXAMPLE, THE EFFECTS OF THE DRUG AT VARIOUS DOSE LEVELS ON PSYCHOMOTOR SKILLS, SUCH AS THOSE USED IN DRIVING.
- (3) FURTHER CONSIDERATION SHOULD BE GIVEN TO WHAT MAY BE NECESSARILY IMPLIED BY LEGALIZATION. WOULD A DECISION BY THE GOVERNMENT TO ASSUME RESPONSIBILITY FOR THE QUALITY CONTROL AND DISTRIBUTION OF CANNABIS IMPLY, OR BE TAKEN TO IMPLY, APPROVAL OF ITS USE AND AN ASSURANCE AS TO THE ABSENCE OF SIGNIFICANT POTENTIAL FOR HARM?
- (4) A DECISION ON THE MERITS OF LEGALIZATION CANNOT BE TAKEN WITHOUT FURTHER CONSIDERATION OF JURISDICTIONAL AND TECHNICAL QUESTIONS INVOLVED IN THE CONTROL OF QUALITY AND AVAILABILITY. (Sec. 464)

SINCE CANNABIS IS CLEARLY NOT A NARCOTIC (SEE [SECTION] 147) WE RECOMMEND THAT THE CONTROL OF CANNABIS BE REMOVED FROM THE NARCOTIC CONTROL ACT AND PLACED UNDER THE FOOD AND DRUGS ACT. (Sec. 467)

WE FURTHER RECOMMEND THAT THE DEFINITION OF TRAFFICKING BE AMENDED SO AS TO EXCLUDE THE GIVING, WITHOUT EXCHANGE OF VALUE, BY ONE USER TO ANOTHER OF A QUANTITY OF CANNABIS WHICH COULD REASONABLY BE CONSUMED ON A SINGLE OCCASION. SUCH AN ACT SHOULD BE SUBJECT AT MOST TO THE PENALTY FOR SIMPLE POSSESSION. (Sec. 468)

The Commission also make the following recommendations related to law enforcement in general as much as to drug laws:

During the initial phase of our inquiry, we have heard bitter complaints and criticisms of the use of entrapment and physical violence to obtain evidence. . . .

WE RECOMMEND THAT INSTRUCTIONS BE GIVEN TO POLICE OFFICERS TO ABSTAIN FROM SUCH METHODS OF ENFORCEMENT, AND THAT THE RCMP USE ITS INFLUENCE WITH OTHER POLICE FORCES INVOLVED IN THE ENFORCEMENT OF THE DRUG LAWS TO TRY TO ASSURE THAT THERE IS A UNIFORM POLICY IN THIS REGARD. (Sec. 469)

WE RECOMMEND THE ENACTMENT OF GENERAL LEGISLATION TO PROVIDE FOR THE DESTRUCTION OF ALL RECORDS OF A CRIMINAL CONVICTION AFTER A REASONABLE PERIOD OF TIME.

In addition to legislation which is actually pending, WE WOULD URGE THE ADOPTION OF THE RECOMMENDATION OF THE CANADIAN COMMITTEE ON CORRECTIONS WITH RESPECT TO RECORDS OF SUMMARY CONVICTIONS WHICH IS AS FOLLOWS:

- (a) *that criminal records resulting from summary conviction be annulled automatically after a crime-free period of two years from the end of the sentence;*
- (b) *that 'end of a sentence' be taken to mean, in the case of a fine or other punishment not involving probation or prison, from the date of conviction; in the case of probation, from the end of the probation period; in the case of prison, from the end of the prison sentence; in the case of parole, from the end of the parole period;*
- (c) *that an annulled record of summary conviction not be activated in the event of any later conviction, which would be dealt with as a first offence.* (Sec. 472)

The report does *not* refer to many other legal issues which require clarification, such as the following:

—The establishment of regional drug analysis laboratories is

- recommended, but what is the legal status of persons bringing drugs for analysis? They have no protection now.
- Innovative services are highly praised, but most persons working there have little legal protection against police action, subpoenas and the like. They have far less protection than do physicians—perhaps not technically, but practically, speaking.
 - Innovative services often treat minors (under 16) without parental consent, and this may involve illegal procedures. They may often deprive persons of their liberty if they are on a bad trip, and there is no legal way of doing this either.
 - Many people would like to know the legality of various procedures engaged in by school officials, e.g., searching students or their lockers, suspending suspected or known drug users, etc.
 - Should solvent-sniffing be defined as a vice for minors, as decided by Judge Little of the Toronto Juvenile Court?
 - The measures used by the Narcotic Control Division in the supervision of physicians treating narcotic addicts are not dealt with.
 - The way in which changes are made in drug scheduling by the Food and Drug Directorate should be examined.
 - Should marihuana convictions affect one's ability to get a civil-service job, a passport, admittance to professional schools, financial bonding, etc.? If not, how can these rights be assured? There are no recommendations relevant to them.
 - It is uncertain whether changing penalties for possession to "fines only" will increase or decrease criminalizing. It has been shown that when unpopularly high penalties are reduced, conviction rates often go up; e.g., when hanging was abolished as a penalty for theft, judges and juries felt more disposed to convict.
 - Are all cannabis recommendations to apply to all forms, e.g., charas, ganja, hashish, delta-9 THC etc.?

- Should it be an offence to give cannabis or other drugs to a minor, a child, an infant?
- What should become of the parts of the (1961) Narcotic Control Act which were passed but not proclaimed? This act provided compulsory treatment for certain types of narcotic addicts.

3. Treatment and Supportive Services

THE COMMISSION SUGGESTS THAT THE MEDICAL PROFESSION, THROUGH ITS REGIONAL MEDICAL ASSOCIATIONS AND LICENSING BODIES, UNDERTAKE IMMEDIATE NEGOTIATIONS WITH PROVINCIAL DEPARTMENTS OF HEALTH FOR THE DEVELOPMENT OF SPECIAL FACILITIES TO TREAT THE SHORT-TERM TOXIC EFFECTS OF DRUG USE. . . .

THE COMMISSION ALSO SUGGESTS THAT SPECIAL CARE BE TAKEN IN THE RECRUITMENT AND TRAINING OF THE PERSONNEL TO STAFF THESE FACILITIES. (Sec. 473)

AT THIS TIME THE COMMISSION MAKES THE FOLLOWING RECOMMENDATIONS WITH RESPECT TO THESE SERVICES, BASED ON THE ANALYSIS IN APPENDIX F [of the Interim Report]:

1. THAT THE FEDERAL GOVERNMENT RECOGNIZE THE NECESSARY AND IMPORTANT ROLE TO BE PLAYED BY INNOVATIVE SERVICES IN COMMUNITIES ACROSS THE COUNTRY. WHERE POSSIBLE, FEDERAL FACILITIES SHOULD BE MADE AVAILABLE TO ASSIST THEM IN INFORMING THE PUBLIC OF THEIR EXISTENCE AND OF THE SERVICES THEY ARE PROVIDING. THEY SHOULD ENJOY THE WHOLE-HEARTED MORAL SUPPORT AND OFFICIAL RECOGNITION OF THE FEDERAL GOVERNMENT.
2. THAT THE FEDERAL GOVERNMENT EXAMINE, WITH THE PROVINCES, THE POSSIBILITY OF PROVIDING MORE DIRECT FINANCIAL ASSISTANCE TO INNOVATIVE SERVICES TO MEET THE PROBLEMS OF FUNDING DISCUSSED IN APPENDIX F.
3. THAT THE FEDERAL GOVERNMENT, WITH THE PROVINCES, ENCOURAGE THE EARLY ESTABLISHMENT OF JOINT COORDINATING COMMITTEES TO SERVE AS INTERMEDIARIES FOR THE RECEIPT AND DISTRIBUTION OF FINANCIAL SUPPORT FOR INNOVATIVE SERVICES IN THE LARGER COMMUNITIES. THESE COMMITTEES SHOULD BE COMPRISED OF A REPRESENTATIVE MEMBERSHIP DRAWN FROM THE COMMUNITY AGENCIES AND INDIVIDUALS HAVING A PARTICULAR INTEREST IN THE WORK OF INNOVATIVE SERVICES. SUCH COMMITTEES COULD BE GIVEN A DISCRETIONARY 'RESERVE FUND' TO HELP WITH THE FINANCING ACTIVITIES OF ITS MEMBER INNOVATIVE SERVICES. THE CRITERIA GOVERNING THE ELIGIBILITY FOR SUCH ASSISTANCE WOULD HAVE TO

BE THE SUBJECT OF DISCUSSIONS BETWEEN THE VARIOUS SERVICES THEMSELVES AND THE APPROPRIATE LEVELS OF GOVERNMENT.

4. THAT THE FEDERAL GOVERNMENT CONSULT WITH THE PROVINCES AND, THROUGH THEM, WITH THE MUNICIPALITIES ON MATTERS OF MUNICIPAL ZONING, PUBLIC HEALTH REGULATIONS AND POLICE PRACTICES AS THEY AFFECT INNOVATIVE SERVICES. IT IS FURTHER SUGGESTED THAT THE MUNICIPALITIES IN WHICH INNOVATIVE SERVICES ARE LOCATED EXAMINE THEIR PROGRAMS IN DETAIL AND, ONCE SATISFIED THAT THEY ARE PROVIDING A NECESSARY SERVICE, DO WHATEVER IS IN THEIR POWER TO FACILITATE THE OPERATIONS OF SUCH SERVICES.
5. NOTING THE RISKS INVOLVED TO THE INNOVATIVE SERVICES IN SHELTERING RUNAWAY YOUNGSTERS WHO ARE AFRAID TO PRESENT THEMSELVES TO OTHER MORE FORMAL INSTITUTIONS, THE FEDERAL GOVERNMENT SHOULD URGE UPON THE PROVINCES THE NEED TO EXAMINE THE PROBLEMS ARISING FROM THE RIGID INTERPRETATION AND ENFORCEMENT OF EXISTING CHILD PROTECTION STATUTES.
6. AS POINTED OUT EARLIER, YOUNG PEOPLE IN NEED OF MEDICAL OR PSYCHIATRIC TREATMENT AS A RESULT OF DRUG USE ARE FREQUENTLY AFRAID TO AVAIL THEMSELVES OF EXISTING FACILITIES IN THEIR COMMUNITIES. THEREFORE, IT IS RECOMMENDED THAT REPRESENTATIVES OF THE MEDICAL PROFESSION, (INCLUDING PSYCHIATRISTS, AND HOSPITAL EMERGENCY STAFFS), PSYCHOLOGISTS AND OTHER MEMBERS OF THE COUNSELLING PROFESSIONS, ESTABLISH SOME SYSTEM OF CONTINUING CONSULTATION AND ASSISTANCE WITH THE INNOVATIVE SERVICES IN THEIR AREAS. (Sec. 474)

THE COMMISSION RECOMMENDS THAT THE FEDERAL GOVERNMENT EXAMINE WITH THE PROVINCES, THE POSSIBILITY OF PROVIDING MORE DIRECT FINANCIAL ASSISTANCE TO SUCH STREET CLINICS. (Sec. 475)

. . . The Foundation itself is currently spending in excess of \$500,000 on provision of services of these types. Roughly \$200,000 of this is on demonstration projects operated by our own staff, \$200,000 on summer student staff seconded to various innovative services in various communities, and \$100,000 on grants-in-aid.

Thought should perhaps be given to the advisability of having government support of innovative youth services contingent upon some program of systematic independent evaluation of the effectiveness of such services.

The remaining observations in this section deal with proposals for further work by the Commission itself:

IN THE COMING YEAR THE COMMISSION INTENDS TO EXAMINE IN DETAIL BOTH THE CONCEPT OF PSYCHOLOGICAL DEPENDENCE AND THE TREATMENT PROGRAMS THAT HAVE EVOLVED, BOTH IN CANADA AND ABROAD. (Sec. 476)

THE COMMISSION RECOGNIZES THAT ONE OF ITS MAJOR TASKS IN THE PREPARATION OF ITS FINAL REPORT WILL BE A THOROUGH EXAMINATION OF THE PROPOSALS FOR LEGISLATION THAT WOULD RESULT IN COMPULSORY TREATMENT OF HEAVY CHRONIC DRUG USERS. (Sec. 477)

4. Prescribing Practices and Controls

It was pointed out during the public hearings that physicians are too often inclined to prescribe the 'easy pill' for insistent and persistent patients to whom they would otherwise have to allocate more time for a personal visit or a therapeutic interview. More specific professional education is needed to make every practicing physician aware of these potential hazards in his prescribing patterns. THE COMMISSION RECOMMENDS THAT THE FEDERAL GOVERNMENT URGE ALL PROVINCIAL MEDICAL LICENSING BODIES TO IMPLEMENT SUCH AN EDUCATION PROGRAM FOR ALL PRACTICING PHYSICIANS. (Sec. 480)

THE COMMISSION RECOMMENDS THAT A SYSTEMATIC STUDY BE UNDERTAKEN OF ALL OVER-THE-COUNTER DRUGS AND THAT THOSE FOUND TO BE ESPECIALLY HAZARDOUS BE DISPENSED ONLY BY PRESCRIPTION. (Sec. 481)

Summary

Our overall reaction to the Commission's interim report is a very favorable one. We are well impressed by its tone of dispassionate objective search for truth, its concern for human welfare, and its philosophical scope and balance.

We agree strongly with its many recommendations for research, and with the areas and objectives of such research. We have suggested additional questions which we consider worthy of research, with rather high priority.

We agree with the Commission's conclusion that legalization of marihuana, or major changes in the legal status of other drugs, cannot yet be advocated on the basis of a

balanced judgement, founded on full knowledge of the consequences of drug use, because such full knowledge is not yet available.

The interim recommendations for a transfer of cannabis from the Narcotic Control Act to the Food and Drugs Act, and for the reduction of penalties for possession of cannabis, are consistent with the views expressed in the Foundation's policy statement on marihuana ("Marihuana and its Effects," *Addictions*, Vol. 15, No. 1, Spring, 1968), with which we still agree. However, if the report is to serve its function of stimulating enlightened public discussion, it should make perfectly clear the issues which must be decided. Such changes in the law would probably eliminate the hardship which is currently visited upon a small but appreciable percentage of cannabis users. In contrast, these changes would probably increase substantially the level of acceptance of drug use in Canada, the total extent of such use, and the frequency of heavy use with an as yet inadequately defined risk of ill effects. The public must make its choice between these two.

In broader terms, we believe that public discussion of all problems associated with drug use should be conducted in the same way: i.e., as an evaluation of the balance between all the perceived benefits and all the perceived harm arising from drug use. Such perceived benefits as pleasure, facilitation of social interaction, and "mind expansion" must be weighed against such costs as psychotic reactions, physical injury, traffic accidents, and expenditures on education and therapy. This would put the discussion in terms of value judgements, which the public at large must ultimately make.

In its final report, we would urge the Commission very strongly to deal with all drugs and not primarily with cannabis. We suggest that they should give as fully as possible their concept of the ideal social response to all the problems of non-medical drug use, and then point out which parts of this ideal response they consider politically and socially

feasible, which parts are not yet attainable, and the reasons for the difference.

Sommaire

Dans l'ensemble, notre réaction au rapport provisoire de la Commission est très favorable. Son ton dépourvu de passion visant à la recherche objective de la vérité, son souci du bien-être humain, de même que sa portée et son équilibre philosophique, nous ont fait une excellente impression.

Nous approuvons entièrement ses nombreuses recommandations au sujet de la recherche, ainsi qu'au sujet des domaines sur lesquels une telle recherche doit porter et des buts vers lesquels elle doit tendre. Nous avons suggéré que cette recherche s'étende également à d'autres sujets valables qui nous semblent avoir une priorité importante.

Nous approuvons également les conclusions de la Commission selon lesquelles la législation de la marihuana ou d'autres modifications importantes de la législation sur d'autres drogues ne peuvent encore être préconisées d'après une évaluation équilibrée fondée sur une connaissance complète des conséquences de l'usage des drogues, parce qu'une telle connaissance n'a pas encore été acquise.

Les recommandations provisoires du rapport visant à ce que le cannabis ne soit plus sous le contrôle de la Loi des stupéfiants mais plutôt sous celui de la Loi sur les aliments et drogues, et voulant que les peines judiciaires pour la possession de cannabis soient réduites, nous semblent conformes aux opinions exprimés par la Fondation dans sa déclaration de principe sur la marihuana ("Marihuana and its Effects", *Addictions*, Vol. 15, No. 1, printemps 1968). Nous appuyons toujours cette déclaration. Cependant, pour que le rapport atteigne son but, soit celui de susciter une discussion publique éclairée, il devrait préciser sans équivoque les questions qui doivent être tranchées. Les modifications à la loi élimineraient probablement les difficultés imposées à un pourcentage faible mais appréciable de consommateurs

de cannabis. Paradoxalement, ces changements augmenteraient probablement, dans une proportion assez importante, le degré d'acceptation de l'usage de la drogue au Canada, l'usage total lui-même et la fréquence de l'usage intensif de la drogue, y compris le risque d'effets nocifs qui n'est pas très bien défini jusqu'à présent. Le public doit faire un choix entre ces deux possibilités.

En termes plus généraux, nous croyons que la discussion publique sur tous les problèmes relatifs à l'usage de la drogue devrait s'orienter dans le même sens. Elle devrait donc porter sur une évaluation équilibrée de tous les avantages et de tous les désavantages connus de l'usage de la drogue. Des avantages connus comme le plaisir, l'amélioration des relations humaines et "l'exaltation de la pensée" devraient être comparés à des effets nocifs comme les réactions psychotiques, les lésions physiques, les accidents de la circulation, de même que le coût des services d'information sur la drogue et des soins médicaux. La discussion permettrait alors d'élaborer les jugements de valeur qui, en définitive, devront être faits par le public en général.

Nous recommandons fortement à la Commission de traiter, dans son rapport final, de toutes les sortes de drogues et non pas principalement du cannabis. Nous suggérons aux membres de la Commission de faire connaître de la façon la plus complète possible quelle est leur conception de la solution sociale idéale à tous les problèmes concernant l'usage non médical des drogues. Nous aimerions aussi qu'ils nous indiquent quels sont les éléments de cette solution qui seraient réalisables politiquement et socialement, quels sont ceux qui ne sont pas possible à l'heure actuelle, et quelles sont les raisons de ces différents aspects de la solution.

A Climatological Theory of the Etiology of Alcoholism

By J. G. T.

The plaintive bleat goes up from the throats of thousands of newly hatched AA members: "Why me? Why am *I* an alcoholic?" Why are any of us? Medical science has failed to crack this problem, but after much deep thought I believe I know the cause: *climate*. Before you jeer, read on.

For starters, consider this writer's environment, up here within spitting distance of Lake Superior, where there are nine months of winter, followed by a few weeks of chinook winds. Every time you look out the window it's snowing, which is splendid for those hardy idiots who ski, skate, or dash around in snowmobiles, but is hell on those who don't. The latter have only work and the friendly tavern, and as time goes on there seems to be less and less delving at one's trade and more and more lingering on a bar stool. Canadians and Alaskans will agree that the cold and dreary climate of the North is a direct cause of alcoholism.

Yet we find very few drunken beachcombers on the shores of Lake Superior, and you rarely see a remittance man. I suspect the same is true of Lake Winnipeg, Puget Sound, or Lake Placid. Only a hot climate seems to foster these dissolute characters, along with sailors who have jumped ship and gone native, lying around all day fanning themselves and drinking palm toddy. So we see that whereas in the frigid North a person has to drink to keep his motor from freezing up, in the Tropics a heavy liquid intake is necessary to prevent his radiator from boiling over. Thus it is evident that a hot climate leads to a drinking problem.

Of course, a fair share of the world lies in the Temperate

J. G. T. is a member of Alcoholics Anonymous in Negaunee, Mich. This article originally appeared in the June, 1970, issue of the *AA Grapevine* under the title "Climate!" and is reprinted with the permission of both the *Grapevine* and the author.

Zone, which is neither hot nor cold, yet has its normal quota of booze-hounds. This would appear at odds with the theory that climate is a causative factor in alcoholism, but there is a logical answer. The people who live in the Temperate Zone are *dissatisfied* with the climate there. About half of them wish it were hotter, while the other 50 per cent would prefer it colder. Since nothing can be done about the weather either way, almost everybody becomes completely frustrated. You guessed it: this constant frustration leads many of them to the bottle.

Getting away from the topic of temperature, we know that parts of the world are very arid, and a dry climate obviously creates problem drinkers. Dryness is the absence of water, and if there isn't enough H₂O around to keep a person dampened down internally, what is he to do? Drink beer, of course, or wine or whisky or any similar nourishing beverage.

The aforementioned "dry theory" is easily understandable. How, then, to account for a goodly number of alcoholics being found in the rain forests of South America, as well as certain parts of the U.S.A. where the sidewalks always seem to be damp? Think for a moment. What would *you* do if you lived where it was pouring rain all the time?

Change of Address

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A.A. Addictions

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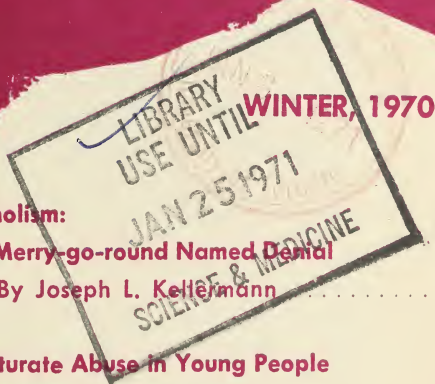
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Alcoholism: A Merry-go-round Named Denial

By Joseph L. Kellermann

A person must have the help of at least one other person to become an alcoholic. He cannot become one by himself. Alcoholism cannot appear in a person apart from others, get worse without the help of others, or continue in isolation from other people.

When a person drinks too much and gets drunk, other people react to this kind of drinking and its results by blaming him. The drinker responds to their reaction with denial, and continues to drink. The downward spiral of this merry-go-round of blame and denial is what we call alcoholism. We can look at alcoholism as a tragic three-act play in which there are at least four characters: the *alcoholic*, the *enabler*, the *victim*, and the *provocatrice*.

To look at the alcoholic, to read a scientific description

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of alcoholism, or to listen to the tales of woe and troubles of the family alone is only a small part of the drama. To understand alcoholism, we must look at the illness of the alcoholic as if we were sitting in the audience watching a play and observing very carefully the roles of all the actors. *Denial* is the name of the play because it is the key word in alcoholism. Again and again the actors do what they say they will not do, or deny what they have done. If we could watch the action on television with the sound off, we could understand much better what is really happening.

The *alcoholic* is the star of the first act. He does all the acting, while the others react to what he does. Usually, he is a male between the ages of 30 and 55, smart, skilful, and often very successful in some area of work; but his goal may be far above his ability, or his performance far below. We see also that he is a very sensitive, lonely and tense person. He acts in a very independent way in order to deny that he is very dependent. At the same time he denies that he is responsible for the results of his independent action. However, if others did not permit this kind of action, he would not be able to act this way.

The alcoholic has learned that the use of alcohol makes him feel better. To him it is a blessing, not a curse. From his point of view, it is a medicine, not a poison. Alcohol melts his fears, reduces his tension, removes his loneliness, and solves all his problems—for the time being. For a few hours, it floats his troubles while he rests. For him, at the moment, it is the answer to all his problems.



Act I

As the play opens, the alcoholic says: "No one ever tells *me* what to do—I tell *them*." And this is true, especially in the family. Talking becomes difficult. Even when the drinking and its results are causing serious problems that everyone

can see, the alcoholic will not discuss them. Talking is a one-way street. No one, on either side, seems to hear what the others are saying.

Early in the first act the alcoholic needs a drink, so he takes one. He drinks more than others, more often than others, and—above all—it means far more to him than to others. He consumes his pain-killer at a rapid pace in large amounts, rather than slowly and easily. He may drink openly; but, more likely, he will hide the amount he drinks by not drinking when the other actors in the play are around.

Hiding the amount he drinks is the beginning of denial, and when we see him do this it proves that he knows he is drinking too much. Drinking too much is not a matter of choice with him but, too often, the first sign of alcoholism. His repeated denial by hiding the bottle and drinking alone tells us that he cannot stop drinking after one or two drinks, and it tells us how important alcohol is to him in making him “feel better.”

After the alcoholic has had a few drinks, we see a profound change in him. Alcohol gives him a sense of success, well-being, and self-sufficiency. It puts him on top of the world, and he acts as if he were a little god. He is now right, and all others are wrong—particularly if anyone objects to his drinking. There is no one thing that all alcoholics do, but while intoxicated or drunk they are not rational or sensible or responsible. They ignore the rules of social conduct and, at times, are criminal in their activity—of which “driving under the influence” is a clear example. If a sober person acted this way, we would say he was insane.

If drinking continues long enough the alcoholic creates a crisis, gets into trouble, or ends up in a mess. Although there are many paths he may take to this end, the action is always the same: a dependent person acts as if he were completely independent; he drinks to convince himself that this is true, but the results of his drinking prove the opposite by making him completely dependent upon others.

When he ends up in a mess he either waits for something to happen, ignores it, walks away from it, or cries for someone to get him out of it. Alcohol, which first gave him a sense of being successful and independent, now has stripped him of his costume of independence and we see him as a helpless, dependent child.

Act II

In the second act, three other characters play out their roles, and the alcoholic receives the benefit of their action. The alcoholic himself does little or nothing but wait for, and expect, others to do things for him.

The first character to appear is the *enabler*. He is a guilt-laden Mr. Clean, whose own anxiety and guilt will not let him endure the condition of his friend the alcoholic. He sets up a rescue mission to save the alcoholic from the crisis or get him out of trouble because he, the enabler, cannot bear the pressure of the situation. He is meeting his own need rather than the need of the alcoholic. As a rule, the enabler is a male outside the family, but at times this role is played by a member of the family or by a woman.

Professionally, the role of enabler is played by ministers, doctors, lawyers, and social workers, who have not had adequate instruction or education on the subject of alcohol or alcoholism. These members of the so-called helping professions act in the same way as friends by denying the alcoholic the right to learn by correcting his own mistakes.

This trains him to believe that there will always be a protector who will come to the rescue, despite the fact that each time they do it the enablers insist they will never rescue him again. They always have, and the alcoholic believes they always will. Rescue operations may become just as compulsive to enablers as drinking is to the alcoholic.

The next character to come on stage is the *victim*, who may be the boss, the employer, the foreman or supervisor, the commanding officer in military life, a business partner, or,

at times, a key employee. The victim is the person who is responsible for getting the work done if the alcoholic is absent because of drinking or is half on and half off the job because of a hangover.

By the time drinking interferes with a man's job he has usually been working for the same company for ten or fifteen years, and his boss has become a very real friend. Protection of the employee is a perfectly normal thing, and there is always the hope that "this will be the last time." Yet, without repeated protection and covering up by the victim, the alcoholic would have to give up his drinking or give up his job. The victim's role is to enable the alcoholic to continue drinking in an irresponsible way and keep his job at the same time.

The third character in this act is the key person in the play: the wife or mother of the alcoholic—the woman with whom he lives. Since she is usually the wife, we recognize that she is a veteran at her role because she has played it much longer than other persons in the cast. For lack of a better term we call her the *provocatrice*—the female provoker.

She is hurt, upset, and provoked by the repeated drinking episodes of the alcoholic, but she holds the family together despite all the trouble caused by the drinking. In turn she feeds back into her marriage the bitterness, resentment, fear, and hurt she feels, and she becomes a source of provocation. She controls, tries to force the thing she wants, sacrifices, adjusts, never gives up, never gives in, and never forgets.

Another name for this character might be the adjuster, for she is constantly adjusting to the crises and trouble caused by drinking and its results. The attitude of the alcoholic is one that allows failure on his part, but she must never fail him. He acts in complete independence, insisting that he will do as he pleases, while she must do exactly what he tells her to do. For instance, she must be at home when he arrives—if he arrives. He blames her for everything that goes wrong within the home and the marriage, and she does

everything possible to try to make the marriage work, to prove that this is not true.

A woman by nature is wife and housekeeper, and may earn part of the bread. If she lives with a man whose illness is alcoholism, she attempts to be nurse, doctor, and counsellor. She cannot play these three roles without hurting herself and her husband. She is so upset by what has happened that she cannot even talk to him without adding more guilt, bitterness, resentment, or hostility to the situation—which is almost unbearable as it is.

Yet everything in our present society trains and conditions the wife to play this role. If she does not, she finds herself going against what family and society think the role of wife is. No matter what the alcoholic does, he ends up at home—for this is where everyone goes when there is no other place to go.

Act II is now played out in full. The results, effects, and problems caused by the alcoholic's drinking have been removed. The mess he made is now cleaned up. He has been rescued, put back on the job, and restored as a member of the family. He again wears the costume of a responsible adult. But since all this was done *for* him and not *by* him, his dependence is increased; he is still a child in an adult suit.

Even the painful results of drinking were suffered by persons other than the drinker, and thus drinking is permitted to become a very effective problem-solving method for the alcoholic. In Act I the alcoholic killed all his pain and woe by getting drunk, and in Act II the trouble and painful results of drinking are removed by other people. This teaches him that he may act in an irresponsible way.

Act III

The third act begins in much the same manner as Act I, but something has been added by the action of the first and second acts. The alcoholic's need to deny his dependence is

now greater. He expresses it almost at once in a louder and stronger fashion. He denies that he has a drinking problem, that he is an alcoholic, that alcohol is causing him any trouble. He denies that anyone helped him. He denies that he may lose his job, and insists that he is the best person at his job.

Above all he denies that he has caused his family any trouble. In fact he blames his family—especially his wife—for all the fuss, nagging, and problems that exist. He insists that she is crazy, that she needs to see a psychiatrist. In more than half the cases, as the illness and conflict get worse, the husband begins to accuse the wife of having affairs with other men—when he knows this is not true.

There are some alcoholics who achieve the same denial by refusing to discuss anything related to their drinking. The memory of it is too painful. Often the alcoholic permits the other members of his family to discuss what *they* did wrong and what *they* failed to do, whether he was drunk or sober. The wife never forgets what her husband does. The husband may not remember what he did when he was drunk, but he never forgets what his wife tells him he did or failed to do.

The real problem is that the alcoholic knows much of the truth that he so strongly denies. He is aware of his drunkenness. He is aware of his failure. His guilt and remorse become so unbearable that he cannot tolerate criticism or advice from others. Above all, his memory of his utter helplessness and failure at the end of the first act is more than embarrassing; it is excruciatingly painful for a man who thinks and acts as if he were a little god in his own world.

In time, the family adjusts to their way of living together. The alcoholic may deny that he will ever drink again, and others in the play give similar promises: the enabler, that he will never again come to the rescue; the victim, that he will not allow another job failure due to drinking; the pro-

vocatrice, whether wife or mother, that they cannot continue to live together under these conditions.

What is said is completely different from what everyone has done and will do again. The enabler, the victim, and the provocatrice have all said these things before, but did not act them out. The result of this ambivalence, however, has been to increase the sense of guilt and failure of the alcoholic, challenge his god-like attitude, and add to his heavy burden of tension and loneliness. If this mental pain becomes unbearable—especially if it is made so by the attitudes and actions of other members of the cast—he will drink again.

It is certain that the alcoholic in Act III will drink again if Act II is played out as described, for he has learned by chance or experience that this is the one and only certain means of removing pain, overcoming his guilt and sense of failure, solving all problems, and recovering a sense of worth and value. The memory of the immediate comfort and benefits of drinking blot out the knowledge of what will happen if he drinks. Also, there is always in the back of his mind the hope that this time he can control his drinking and get the great benefits from it that he once did. So, what seems absolutely necessary to the alcoholic occurs. He takes another drink.

When he takes the drink, the play does not come to an end. The curtain closed at the end of Act I and Act II, but at the end of Act III the play suddenly returns to the first act without the curtain closing. It is like watching a three-reel continuous-play movie that runs without stopping at any point. If the audience remains seated long enough, all three acts will be played out again in the same way and, at the end of Act III, the alcoholic will start to drink again. As the years go by the actors in the play get older, but there is little change in the words or the action of the drama.



If the first two acts are played as described, then Act III will follow in the same way. Without Act I, of course, the play about alcoholism would have no beginning and the drama surrounding it would not exist. This leaves Act II as the only act in which the tragic drama of alcoholism can be changed—the only act in which recovery can be initiated by the decisions and actions of persons other than the alcoholic.

The key to this fact is that in Act II the alcoholic accepts what is done for him by others, who do these things for him either by choice or because they cannot resist doing them. Act III has the real potential to break the downward spiral of alcoholism and its merry-go-round of denial.

It is completely untrue to state that an alcoholic cannot be helped until he wants help. However, we can truthfully state that there is almost no chance that the alcoholic will stop drinking as long as other people help him keep on drinking by removing all the painful consequences of drinking.

The actors in the second act kept asking the alcoholic why he did not stop drinking, and yet they were the very persons whose actions helped him solve his problems by drinking in this way. If the alcoholic is rescued from every crisis, if the boss allows himself to be victimized again and again, and if the wife reacts as a provoker, there is not one chance in ten that he will recover. The alcoholic is virtually helpless, locked in by his illness. He cannot break the lock by himself, but neither can he keep the merry-go-round going unless others ride it with him and help him keep it going.

A planned recovery from alcoholism must begin with the actors in the second act, who hold the key to the lock. If they succeed in breaking the lock, or removing it, the alcoholic is free to come out. These actors cannot demand that the alcoholic give up drinking as a means of solving his problems, but they may be able to help him recover if they

learn how to break his dependence on them by refusing to give in to him.

To do this they must learn how people affect each other in this illness, and they must learn to act in an entirely different fashion. The latter is the more difficult part. New roles can be learned by turning to others who understand the play, and putting into practice the insight and knowledge gained from these sources.

The people in the second act will find it painful and very difficult to change. It will be much easier and far less painful for them to keep on saying that "the alcoholic cannot be helped" than to go through the pain and agony of learning to play new roles. However, if Act II is rewritten and replayed, there is every reason to believe that the alcoholic will recover.

The enablers and the victim must seek information, insight and understanding if they plan to change their roles. It is usually necessary for the wife or mother, as provocatrice, to become active in a program of counselling and therapy if she is to make a basic change in her life.

In trying to understand the roles of the three supporting actors in this drama, we must remember that they did not learn them overnight. These people play the role that they think is expected of them; they have been taught by others to act in this way. They think they are helping the alcoholic, and do not know that they are perpetuating the illness and making it virtually impossible for the alcoholic to recover.

Friends who are enablers think they must not let the alcoholic suffer the consequences of his drunken behavior when they can be so easily removed by a simple rescue operation. They feel that this is something that simply must be done—like trying to save a drowning man. The rescue mission relieves their fear, guilt, and conscience. It also conveys to the alcoholic what the enabler is really thinking: "You cannot make it without my help." This thought reveals

a lack of faith in the alcoholic's ability to take care of himself, and is a form of judgement and condemnation.

The most destructive aspect of the role of the professional enabler—minister, doctor, lawyer and social worker—is that the family is trained and conditioned to rescue the crisis rather than use it to start a recovery program. By the time the alcoholic begins using professional enablers, the family has known for five to ten years that drinking is a serious problem—even though this fact was not visible to people outside the family.

During this earlier period of alcoholism, before the alcoholic behavior can be seen by outside persons, the family is told by professional persons that the drinker is not an alcoholic and, even if he were, there is nothing they can do unless he actually wants help. Later, when alcoholism reaches the point of outside visibility and the alcoholic turns to professional persons for help, they respond by reducing the crisis.

This is what happens. When alcoholism is in the early stages the family is told that there are no signs of alcoholism. Then, when it becomes visible the family is taught that the way to deal with it is to remove the symptoms and results rather than come to grips with the problem. They learn this when the professional persons who failed to identify alcoholism in its earlier stages treat the more advanced symptoms by reducing the crisis.

This kind of help and treatment does not lead to recovery. On the contrary, it makes the illness chronic, helps the alcoholic get back on the merry-go-round, and teaches the family again and again that "nothing can be done to cope with alcoholism." When the family is forced to accept the existence of a serious drinking problem, to admit that it is alcoholism, and to turn to professional persons for help for themselves and for the alcoholic, the professional person acts out the role of enabler instead of leading the family and the alcoholic into a long-range program of recovery.

The victim does not get on the merry-go-round until the alcoholic has been working for many years. Large industrial firms have discovered that when alcoholism begins to interfere with a man's work he has been employed for ten, fifteen, or twenty years in most cases. The foreman protects his alcoholic friend, knowing he has a wife and children who will suffer if the man is fired.

This is especially true if there is no company policy to help alcoholics recover. Fellow workers also protect the alcoholic's job because this man is their friend. Personal interest and friendship cause the victim to do for the alcoholic things that increase his dependence and add to his need for denial.

The wife, or provocatrice, is the first person who joins the alcoholic on the merry-go-round. If she absorbs injustices, suffers deprivation, endures repeated embarrassments, accepts broken promises, is overthrown or undermined in every effort to cope with the drinking situation, and is beaten by the constant expression of hostility directed towards her, she will automatically feed back into the marriage her own reaction of hostility, bitterness, anxiety, and anger. Playing the role of provocatrice in this way makes the wife sick.

She is not a sick woman who forces her husband to become an alcoholic, but a woman who becomes part of an illness by living with it. She is put in a role which encourages her to become a female provoker, the provocatrice. She is caught between the advancing illness of alcoholism and the wall of ignorance, shame, and embarrassment inflicted upon her by society. This crushes her, and she needs information and counselling—not because she caused her husband's illness, but because she is being destroyed by it. This, in turn, hurts the alcoholic and greatly reduces his chance of recovery.

Another reason why the wife needs help in the plan of recovery is that she will discover she is standing alone if she changes her role and begins to act in a new way. Other members of the cast will treat her as an actor who has

deserted a play when there is no understudy to take her part. This is especially true if the wife separates from her husband, whether by choice or by necessity.

Some wives can change their role after having a few talks with a counsellor who has some basic knowledge of alcoholism, or by attending group meetings in a local alcoholism clinic or mental-health clinic. Others gain insight and security by taking part in Al-Anon or family group meetings.

Having new friends who understand her new role—because they have lived through the pain and agony of their own change—is very important to the wife at this time. As relatives and old friends begin to tell her how wrong she is in trying to play a new role, the wife needs people who understand the situation and can give moral support in her search for answers to the problems of alcoholism.

The most basic mistake made by women who seek help for their husbands' alcoholism is that they want to be told what they can do to stop the drinking, without realizing that it may take months or a year or two for them to learn a new role in the alcoholic marriage. Six months of regular weekly conferences or group meetings are often necessary before a wife begins to change her feelings and learns to act in a new way. If others in the play do not learn new roles, the wife may need to remain in the group for a period of two or three years before her feelings and emotions will permit a change in role.

The wife enters into this activity of seeking help for herself because she needs this help to recover from her own fears, anxieties, resentments, and other destructive forces at work in an alcoholic marriage. As she is able to change, this may change the drinking pattern of her husband, and in many cases such a change leads to recovery on the part of the alcoholic. Few husbands can stand a drastic change in their wives without making basic changes in their own lives, but this desirable result cannot be guaranteed. Many wives seek some form of help and then drop out of a pro-

gram when the problems of their alcoholic marriages are not solved in a short time.

If there are children in the family with an alcoholic husband, the wife must seek help outside the family or the circle of her own friends if she is to avoid injury to the children. Playing the role of provocatrice places the children between a sick father and a sick mother. The wife who seeks and finds help early enough can prevent much of the harm that is being passed on to the children through her reaction to her husband. The wife who plays the role of provocatrice for the sake of the children is hurting them rather than helping them.

The wife must first seek help for herself. If she finds this help, it will protect the children in many ways and may open the door to her husband's recovery—which otherwise might not occur. The rate of recovery increases greatly when the wife seeks help for herself and continues to use this help while seeking additional help for her husband.

Morally, no one has a right to play God by demanding that the alcoholic stop drinking. The reverse is also true. The alcoholic must have a supporting cast so that he can act as if he were a little god by telling everyone what to do while he does as he pleases. The wife has every moral right and responsibility to refuse to act as if her husband were God Almighty whose every wish and commendment she must obey.

As a rule she cannot tell her husband anything, because he refuses to hear it. Her only effective means of telling him what she means is to learn to act in freedom from his attempt to control and dictate what she is to do. Since this control may be exercised in silence and need not be expressed in words, the real message to the wife is what the husband does, not what he says. This is why she, too, must learn to act in a new way so that he will get her message.

Two things prevent most wives from remaining in long-range programs. First, the husband's attitude towards the new

role may range from disapproval to direct threats or violence. Second, responsibilities in the home, particularly if there are young children, make it very difficult for the wife to leave the home for group meetings, counselling or therapy during the day. At night few alcoholic husbands will baby-sit or pay for this service while the wife attends meetings of Al-Anon.

If the couple married at an average age—during the pre-alcoholic stage of his illness—the wife is the first person who joins him on the merry-go-round when alcoholism appears. It is not until many years later that the enabler and the victim start their roles. Therefore, if recovery from alcoholism is to be initiated before the illness becomes crucial or acute, the wife must initiate the recovery program. Since most people today, including the helping professionals, are unwilling to accept alcoholism as an illness until it reaches the addictive stage of chronic alcoholism, the wife will find herself in the position of a pioneer in the search for help.

If her minister condemns drunkenness, she is ashamed to turn to him. If her doctor fails to recognize the existence of alcoholism in the early stages, medical help and counsel for her are cut off. If conditions become unbearable and she consults a lawyer, he may talk in terms of separation or divorce as the only real service he can offer. This increases her sense of failure as a wife, or terrifies her with immediate feelings of anxiety and grief—reactions she would have if she took such action. Therefore, most wives stay on the merry-go-round, or get back on soon after trying to get off.

Until there are drastic changes in our cultural and social attitudes towards drinking and alcoholism, the wife or family member who wishes to initiate a process of recovery from alcoholism must understand that it can be a long and difficult undertaking. However, since she cannot make such a moral choice unless she believes it to be right, she must understand the nature of alcoholism in order to make it.

We cannot expect the wife to do what is beyond her emotional or financial capacity. However if she (or some other

family member) is willing to enter into a weekly program of education, therapy, Al-Anon or counselling, and work at it for a period of at least six months, changes usually occur not only in her life but often in the life and action of the alcoholic.

She must also have the courage to stand against her husband's initial opposition and effort to destroy her own program of recovery, if he takes this position. By remaining in a program of her own for months or even a year or two, she may be able to solve problems which at first seemed too difficult to try.

There is no easy way to stop the merry-go-round, because it is more painful, at that particular time, to stop it than to keep it going. To spell out definite rules that apply to all members of the cast is impossible. Each case is different, but the framework of the play remains the same. The wife or family member is able to see the merry-go-round of the alcoholic, but often fails to see that she is the one who provides the help that keeps it going.

The hardest part of stopping the repeated cycle is overcoming the family member's fear that the alcoholic won't make it without such help, even though it is the kind of help that permits him to continue to use alcohol as the cure-all for his problems of life.

If a friend is called upon for help, he should use the occasion as an opportunity to lead the alcoholic and the family into a planned program of recovery. The professional person who has alcoholics or their family members as clients or patients should learn how to cope with alcoholism. Specific literature is available through local, state or provincial, and national programs on alcoholism. Short, intensive workshops are also available for professional persons who are willing to spend time and effort learning the basic facts about alcoholism.

If a wife thinks her husband has a drinking problem or drinks too much too often, she should seek help and counsel

immediately for the purpose of evaluating the situation. If a wife *knows* her husband has a drinking problem, she should seek information and counsel in order to find and take part in the programs best designed for her and her needs.

Regardless of the kind of help the wife chooses she should not stop after a few conferences or meetings, because changes do not occur overnight. Regular attendance should be continued for months, or even a year or so, for many wives state that it takes them this long to secure the real benefit from a program. This may not seem fair to the wife, but in our present society she has one basic choice—to seek help for herself or permit the illness of alcoholism to destroy her, other members of the family, and perhaps her marriage.

Al-Anon is the most widespread group resource for the family today, just as Alcoholics Anonymous is the most readily available help for the alcoholic. Each have several thousand groups throughout the United States and Canada. In many communities there are also alcoholism information centres, mental health centres and professional people who have learned enough about alcoholism to give good professional counsel to the family. If she makes a real search, the wife can find a source of help for herself—the only effective method if she is to break the merry-go-round of denial during the early period of alcoholism.

Once help is found, the family member must continue to use whatever help is available and build her own program of recovery, preferably within an established group. Starting a recovery program may cause greater suffering, conflict and confusion initially, but in the long run it will be far less painful than helping the alcoholic continue to drink by remaining a member of the supporting cast of the play that keeps the merry-go-round turning.

For those who may wish to structure the merry-go-round with the wife as the alcoholic, the process is quite simple. In the second act, all three supporting roles are played by the husband. If he wants his wife to recover, he must change

all three roles. To do this, he needs more help than does the wife of the alcoholic husband. He will probably deny that he needs help—but, after all, that is to be expected: the name of the play is *Denial*.

Here are four simple guidelines to aid the family of the alcoholic:

1. Secure additional alcoholism literature for your own study.

2. Seek out all professional alcoholism services in your community. Use whatever is available for the family, and know what is available for the alcoholic.

3. Attend Al-Anon regularly in addition to using professional services. If Al-Anon is not available, attend open meetings of Alcoholics Anonymous.

4. Remember that the family may either help keep the illness going or start the recovery process. The family should work towards recovery by starting and continuing a change in their roles in the drama of alcoholism.

Monsieur Kellermann est ministre épiscopalien et directeur du Charlotte (Caroline du nord) Council on Alcoholism. Il propose de regarder l'alcoolisme comme un drame tragique dont l'alcoolique est le héros. Les acteurs secondaires—sa femme, son employeur et les autres—l'aident à jouer son rôle d'alcoolique en l'empêchant de subir les conséquences de son comportement. A la fin de l'acte III, les acteurs se retrouvent au début de l'acte I et rejouent la pièce au complet. Enfin, la pièce connaît un dénouement alors que les rôles de soutien refusent de jouer conformément au scénario et forcent ainsi l'alcoolique à assumer la responsabilité de son propre comportement. Monsieur Kellermann donne quelques suggestions au sujet de la façon de provoquer un tel dénouement.

Barbiturate Abuse in Young People

By Paul Devenyi

It seems that young non-alcoholics who abuse barbiturates do so in an entirely different way from older alcoholics. Other workers have reported this on the basis of their own investigations,¹ but we on the staff of the Addiction Research Foundation's Medical Unit in Toronto (the Hastings Unit) had the opportunity to learn it for ourselves recently by studying a sample of 38 young non-alcoholic drug abusers.

The opportunity arose as a by-product of a study of barbiturate abuse in a much larger sample of alcoholics, who were mostly older people. The larger study was reported—by myself and Mary Wilson, the head nurse at the unit—to the Fifth Canadian Conference on Alcoholism, which took place at Halifax in June of this year.²

We began the report of our larger study by surveying the literature, which, in brief, shows that barbiturates—certain barbituric acid derivatives, which physicians often prescribe as sedatives and sleeping pills—are often abused. In some users, barbiturate abuse is relatively mild and infrequent; in others, it amounts to frank physical dependence. In the latter cases, the user has developed a tolerance to barbiturates: he needs to keep increasing his dosage in order to get the effect he wants; if he suddenly stops taking the drug, there is a fair risk that he may develop severe withdrawal symptoms—delirium, or convulsions, or both—and there is some risk that he may die.

Anybody who takes a high dose of a barbiturate runs certain risks, whether he is physically dependent or not. In persons who have not built up a tolerance to barbiturates,

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relatively low doses can produce severe intoxication with consequent risk of accidents. Persons who have developed a tolerance to barbiturates may show no impairment at moderate doses, but show severe impairment at high doses.

At the level of the lethal dose, tolerance makes no difference: tolerance to barbiturates—and to alcohol—is quite unlike tolerance to opiates or amphetamines. A junkie or a speed freak can take doses of heroin or methamphetamine, respectively, that would kill a novice; but, if other factors are equal, a dose of a barbiturate that would kill a person not physically dependent on barbiturates will also kill an addict. For this reason, workers in this field describe tolerance to barbiturates or alcohol as “incomplete.”

Following our review of the literature, we described our own study of barbiturate abuse and dependence in the alcoholics we have seen in our own unit. On the basis of information obtained from 893 alcoholics who were or had been patients in the unit, we found that 129, or about 15 per cent, had also abused other drugs; of these, 89, or about 10 per cent, had abused barbiturates—either alone or in combination with other drugs. In other words, of those subjects who reported having abused other drugs, about 70 per cent reported having abused barbiturates. For the purposes of this study we defined “abuse” as any use of drugs obtained from non-medical sources, any use of drugs for non-medical reasons—including the use of medically prescribed drugs for purposes other than those they were prescribed for—or any use in excess of a prescribed dosage.

Working with the case records of those alcoholics who reported having abused barbiturates, we made some further findings. The mean age of this group was 40.9—slightly lower than the mean age of our total alcoholic patient population, which was 47.8. The ratio of males to females was 3 to 1—slightly lower than the male-to-female ratio of the total alcoholic patient population, which was 5 to 1.

Of this group, 71 per cent reported that the purpose of

their barbiturate abuse was to get the intoxicating effect—either of the barbiturate alone, or of the barbiturate in combination with alcohol; in 33 per cent of the cases, it was clear that physical dependence had been present at one time or another, either because the subject had developed withdrawal symptoms or because he had to be withdrawn from barbiturates when he was admitted to hospital.

We found that 38 per cent of the group had at some time taken an overdose that caused stupor or coma, or that made hospitalization necessary. In nearly half of the overdose cases, the overdose was apparently accidental—the subject was intoxicated, either by a barbiturate alone or by a barbiturate and alcohol, and was confused about how much he had already taken. Finally, 53 per cent of the group reported that the source of part or all of their barbiturate supply was by prescription from a physician.

At the same time as we were conducting the study of barbiturate abuse in alcoholics, it occurred to us that we might also learn something worth knowing if we studied barbiturate abuse in another identifiable patient group: the younger non-alcoholic patients. For this study we excluded all patients over the age of 25, and all patients whose primary drug problem we judged to be excessive alcohol consumption. This left us with a group of 38 subjects, the youngest of whom was 15, and whose mean age was 19. The reader may recall that the mean age of the barbiturate-abusing alcoholic sample was 40.9 and of the total alcoholic patient population 47.8.

There were 23 males and 15 females in this sample, giving us a male-to-female ratio of 1.5 to 1—compared with a ratio of 3 to 1 for the barbiturate-abusing alcoholic sample and 5 to 1 for the total alcoholic patient population.

Most of this sample reported having used an assortment of drugs that included marihuana, LSD, amphetamines, and a variety of other substances. Four subjects reported a preference for opiates, and three for solvent-sniffing. We got a

strong impression that there was a marked increase in preference for methamphetamine, taken intravenously, among those subjects who presented themselves as patients to the unit in the last year of the study—from spring, 1969, to spring, 1970—but the information we have collected about this so far is not enough to be statistically significant.

Of all these subjects, one-third reported using varying amounts of alcohol on occasion, but not to the extent that alcohol use constituted a problem.

Of the 38 subjects, 56 per cent had used barbiturates at least once. Since the source of their barbiturates in all cases was other than legitimate—the subjects had obtained the drugs either on the black market or from somebody else who had got them on prescription—all of this barbiturate use constitutes abuse according to the definition we used in the study of alcoholics.

Thus the finding that none of the barbiturate abusers in this study had obtained their barbiturates by prescription compares with the finding in the study of alcoholics that 53 per cent of the barbiturate abusers obtained part or all of their supply by prescription.

Only one subject in our sample of 38 young people reported barbiturates as her drug of choice; and this subject was the only one who reported having had barbiturate withdrawal symptoms—convulsions, in this case—which we take to be the primary indicator of physical dependence. This contrasts with the 33 per cent of the sample of barbiturate-abusing alcoholics who had been physically dependent on barbiturates at one time or another; and, of course, barbiturates are the primary drug of choice for a large number of older people. Most of the subjects in this study of younger drug abusers who used barbiturates said that they did so to counteract certain effects of other drugs they had been using: to terminate an LSD trip, or to get to sleep after an amphetamine spree.

Barbiturate abuse occurred most frequently in those sub-

jects who said their primary drug of abuse was methamphetamine: 68 per cent of these subjects reported having used barbiturates at least once. The least frequent abuse of barbiturates occurred in those whose primary drug of abuse was one of the volatile solvents: none of these reported ever having used barbiturates.

In general, recent studies of the use of drugs in large populations of young people by such researchers as Smart, Whitehead, and Laforest, suggest that barbiturates play a very minor role: typically, these studies report that less than 6 per cent of respondents have used barbiturates at all, and that most respondents who have used barbiturates have used them only occasionally.

Our own study suggests that even among young people who have developed serious enough problems through the use of drugs that they need to be admitted to hospital, the use of barbiturates is marginal: these young people seem to use barbiturates mostly as accessories to other drugs whose effects they value more highly. Thus barbiturate abuse among young people does not present as serious a clinical problem at the present time as it does among adult alcoholics and pill-heads.

Nevertheless, the relatively high proportion of subjects in this study who reported having used barbiturates at least once—56 per cent—suggests that barbiturate abuse could become more prevalent among young people at some future time. If this happens, we can expect a high incidence of physically dependent users and a high incidence of deaths related to barbiturate use.

There are several reasons for making this prediction. To begin with, it is relatively easy to obtain barbiturates: on the black market, or from people for whom they were originally prescribed, or from physicians with lax prescribing habits.

Secondly, the regular use of barbiturates induces tolerance, making it necessary for the user to keep increasing the

dosage. Eventually this process results in physical dependence.

Thirdly, physical dependence on barbiturates carries a greater risk to life than physical dependence on opiates, because withdrawal from barbiturates is sometimes fatal—whereas most authorities now agree that withdrawal from opiates is never fatal.

Finally—largely because of the phenomenon of incomplete tolerance—regular abuse of barbiturates is the most dangerous form of drug abuse, in terms of the possibility of accidents during intoxication and the possibility of taking a lethal dose.

Thus the apparent high incidence of barbiturate abuse among young drug abusers—even though this use is marginal at the present time—suggests that it would be a good idea to make sure that the facts about barbiturates that are now well known to the scientific community are communicated to the public, and especially to young people.

References

1. See, for example, Unwin, J. R., "Illicit Drug Use Among Canadian Youth" (Part II), *Canadian Medical Association Journal*, Vol. 98, pp. 402-407, 449-454 (Feb. 24 and March 2), 1968.
2. Devenyi, P., and Wilson, M., "Barbiturate Abuse and Addiction in Alcoholics," paper presented to the Fifth Canadian Conference on Alcoholism, Halifax, N.S., June 2, 1970 (to be published).

Le docteur Devenyi et certains de ses collègues ont étudié le comportement d'un groupe de jeunes usagers de la drogue, non alcooliques, afin de déterminer le degré et la nature de l'abus des barbituriques chez eux. Leurs observations laissent entendre que l'abus des barbituriques chez ces jeunes n'est pas fréquent. Les barbituriques sont rarement les drogues que l'on préfère et sont employés surtout pour réagir contre certains effets indésirables d'autres drogues, par exemple pour mettre un terme à un "voyage" au LSD ou pour pouvoir dormir après avoir absorbé une forte dose d'amphétamines durant une période prolongée.

AA and Other Treatment Programs: Problems in Co-operation

By Charles Aharan

January, 1971, will mark the twentieth anniversary of my first contact with Alcoholics Anonymous. As I look back now, I realize that it was one of the most significant events in my life. Not only did I become familiar with this remarkable fellowship, but it was the starting point of my life's work.

I was doing postgraduate work at the time of my initial contact with AA; as a result of this contact, I became fascinated with the problem of alcoholism and with the therapeutic power of AA. I did the research for my M.A. thesis in this area, and about two and a half years later I was asked to establish the first treatment centre for alcoholics in London, Ontario. AA has shaped my ideas about recovery programs; my friends in AA, who shared with me their experience with alcohol and their opinions about alcoholism, have shaped my ideas about alcoholism and the alcoholic.

I often discuss AA with professionals. When I do, I talk about the attitudes that many of my professional colleagues possess, which I believe prevent them from working effectively with AA. In this article I am going to discuss some attitudes and practices I have often observed among AA members, which I believe prevent many of them from working effectively with professionals. I believe that the essential AA philosophy is unassailable; what I intend to deal with here are attitudes and practices of individuals that occur

Dr. Aharan is Director of the Lake Erie Region of the Addiction Research Foundation. This article is adapted from a talk he gave at the 35th Anniversary International Convention of Alcoholics Anonymous in Miami Beach, Florida, in July, 1970.

often enough to be mistaken, by the uninformed, for expressions of AA philosophy.

The first requirement for successful co-operation between AA and non-AA treatment services is a spirit of good will, generated out of the common goal of being helpful to those who are still suffering. The most effective working relationship is one in which each tries to complement the other, rather than trying to compete. For this spirit of co-operation to exist, the welfare of the still-suffering alcoholic must take priority over all other considerations.

The starting point, then, is in the quality of our concern. It seems to me that co-operative attempts often degenerate into a battle, in which each group tries to demonstrate the superiority of its own technique and philosophy; when this happens, the suffering alcoholic gets lost in the struggle.

There are many personal characteristics that contribute to effective co-operation, but I believe a fundamental quality necessary in all parties is humility. For co-operation to be effective, all concerned must be aware of their own limitations, must be aware of the possibility that the other people they are trying to work with may be sincere, and must be aware of the possibility that they might learn something from these other individuals.

I do not believe that a recovered alcoholic is necessarily an expert on alcoholism, although he may be. In my view, a recovered alcoholic in AA is an expert on his own experience and on his own way of working the program. When he ventures beyond his own experience, starts to proclaim on the nature of alcoholism and the role of alcohol in society, and becomes involved in preventive education programs, I believe he is risking his credibility as a potentially valuable partner in the eyes of many professionals.

A recovered alcoholic in AA can be knowledgeable and skilled in helping; and it is in the area of helping that the co-operative endeavor should take place. Everybody is entitled to his own opinion about the nature of alcoholism; but

these opinions are often irrelevant in terms of developing effective helping relationships. Co-operative undertakings often fall apart because of disputes about the nature of alcoholism. It is necessary for all of us, in trying to work together, to remember one of the AA slogans: "Keep an open mind."

Many AA members seem to believe that alcoholics are a special breed, entitled to special recognition and consideration. It sometimes seems to me that they claim to have the world's market on suffering all sewn up. An extension of this view is the frequent assertion by AA members that only an alcoholic can understand or help an alcoholic. I agree that an alcoholic has a tremendous advantage in communication, but I do not agree that only an alcoholic can relate meaningfully to an alcoholic.

I do not know how it feels to be an alcoholic, but I know what fear, remorse, shame, guilt, uncertainty, and despair feel like. These feelings are shared by all human beings: we are brothers in frailty. The superiority of AA is secure; it does not need to be reinforced by emphasizing the failure of others.

We need to ask ourselves why we are so ready to believe almost everything we hear about certain individuals and groups. What personal needs are we satisfying by our uncritical acceptance of unverified stories? Alcoholics often describe themselves as con artists; as con artists, they should realize that one of the most effective ways to con somebody is to find out what he wants to hear and then feed it to him.

The practising alcoholic often tries to gain special recognition and attention by telling his AA friends or sponsors what he thinks they want to hear about his attempts at getting help from treatment agencies. He also tells stories to treatment agencies about the help he did not get from AA. I believe that people in treatment services and in AA would be well advised to verify the stories they hear about each other before they pass judgement. I have had many alco-

holics come in to me and try to rationalize their personal failures away by blaming AA. I know better, and I tell them they are talking nonsense.

I would like to suggest that when an opportunity comes to AA members to work in a co-operative way with treatment programs, wherever possible they should find out the treatment philosophy of the unit that seeks their assistance. It would be desirable to meet with the relevant people in the treatment centre and discuss with them their view of what constitutes adequate treatment. An AA member who did this would be giving himself a chance to find out if the treatment staff practised in a manner he could accept.

If he found out that they did not practise in such a manner, and that they would not change, I think he should say, in effect: "When you have finished with the patient, I will be glad to help in any way I can." I think this would be infinitely better than trying to work with a treatment centre—and, more particularly, trying to work with patients from a treatment centre—where the philosophy of the staff is markedly different from that of the AA member; that kind of contradictory relationship can only result in damage to the suffering alcoholic.

I have had the experience of being present at AA meetings where I have heard the speaker say that Antabuse was of no earthly use, or that our own treatment centre was of no earthly use. I respect the speaker's right to his opinion and, probably, his right to state it; but I cannot help feeling sad when an individual is sitting beside me who trusts me, who believes in my competence, whom I have been persuading to go to AA, and whom I have taken to AA myself. I know of no way to overcome this kind of problem, except perhaps through an emphasis on the individual nature of the AA program and on the importance of keeping an open mind.

The true basis for co-operation resides in the awareness that love and tolerance must be inclusive: it cannot be limited

to the members of one's own group, or to members of AA; it must embrace all mankind.

I would like to mention two additional points about working together. The first relates to the problem of the recovered alcoholic in AA who finds himself employed in a treatment centre as a counsellor. I believe that the AA member in this position has to reconcile a number of issues. Perhaps one of the most difficult problems he has to deal with is the temptation to become the interpreter and spokesman for AA at the treatment centre and for the treatment centre in AA.

I believe people in this situation would be wise to avoid this problem by taking the position that they are going to an AA meeting for the sake of their own sobriety, not to act as a spokesman for any other group. As a matter of fact, I cannot think of any other reason why an AA member should go to an AA meeting.

One final point about co-operation. In my experience, there is a tendency on the part of many AA members to use the treatment facility as an easy way of doing Twelfth Step work. During our early experience at our own centre, I found many times that we were being used as a dumping ground. I never objected to trying to help, but I often felt that the alcoholic was not getting the full benefits of AA sponsorship.

In the latter part of this article I would like to describe an idea that is of interest to me and about which I would like to get some feedback. It has to do with some implications of the social and technical changes that have taken place in the first thirty-five years of AA's history.

In many important ways, the society that gave birth to AA is not the society of today. AA's continued relevance is a testimony that AA, when it was founded, was ahead of its time. But the need to stay relevant is complicated by the rapid changes that are taking place.

Principles are constant over time, and should not change; but practice can change, and terminology can change. AA pioneered in the development of a new approach to troubled

people, and future historians will record its impact on the theory and practice of the helping professions. I have been wondering lately if there was some way that AA could use some of the procedures that have been developed in the social and behavioral sciences that have grown out of AA's impact: I am thinking particularly of the developments in group process.

I believe that one of the great strengths of AA is its ability to communicate, in a compelling way, basic principles to live by; but I think it could strengthen its communication about how to do it. I believe this is particularly the case in the management of troublesome feelings that interfere with satisfying interpersonal relationships and personal growth.

I have often had the feeling that, for many AA members, how long they have been sober has become more important than how sober they have managed to get. Concern about the quality of sobriety means that an individual should not remain contented and complacent because he is a sober man; he must be concerned with what kind of sober man he is. I believe it is sometimes too easy for a person to imagine that he has won the battle when he has achieved abstinence. The Twelve Steps emphasize the quality of sobriety—which is just another way of saying “the quality of life”—but the practice of many individuals and the character of some groups does not.

In any group of human beings, there are certain ways of behaving that encourage identification between the individual and the group. In AA there is a language and a style, and in some groups there are traditions that are unwritten and unspoken. In some groups, if a person wants to be recognized as a member in good standing, he does not speak about his fear of people, his inability to work or even to understand all aspects of the program, the fact that he often behaves badly, or that he is unhappy and depressed—even

if all these things are true. Instead, he feels that he must tell an unqualified success story or not speak at all.

Many people in AA—new and old members alike—have approached me with the concern that there is something wrong with them. They tell me they like and need AA, but there is something wrong; it is not working for them as it does for the others. They tell me they are often unhappy, that they are nervous at meetings—frightened that the chairman may ask them to read the Twelve Steps or thank the speaker—or that they are bored and fed up.

They think they are different—that they are failures—because they seldom hear speakers or other members frankly admit to having the same kinds of feelings. If they do not blame themselves, they sometimes react in a much more destructive manner and decide that all the talk about happiness and contentment is just so much hot air.

New AA members often experience troublesome fears and discouragement; old AA members often experience apathy, loss of enthusiasm, and disillusionment. A person can resolve these problems—often with ease—if he can admit them and share them; his ability to do this is influenced by the degree of openness there is in his group. To me, a person's success in AA is not characterized by the elimination of troublesome personal conflicts, but by a growing confidence on his part that with application of the program in his life he will be able to cope with his problems. Working the program is not demonstrated by the absence of pain, but by the feeling that one can cope with pain.

AA members are usually tolerant to the expression of continuing problems related to the use of alcohol, but they are not tolerant to the expression of many other problems of living. By openly sharing the kind of problems I have mentioned, an individual puts himself in a position to be helped and also to help others who feel the same way.

In recent years, a great deal of progress has been made in the area of group dynamics. Methods have been developed

that are easy to learn and that are remarkably effective in helping people to be more open and real in their relationships. I wonder if it would be feasible for AA to undertake the development of one or two centres for training and development in human relations and group process.

Members who attended such a centre would not achieve any special status in AA; they would be in no sense professional. They would achieve a meaningful and valuable personal experience and would, as a result, be more helpful AA members. They would be inclined to acknowledge and share the problems I have mentioned, and would be more sensitive to these problems in other people. People who have had the kind of experience I am referring to could add a new dimension to their group. Finally, and most important, it could be a growth dimension that would help AA members to evolve to deeper levels of self-knowledge and appreciation of the AA program.

Le Dr Aharan, directeur de la région du Lac Erié de l'Addiction Research Foundation, connaît les Alcooliques Anonymes depuis vingt ans. Dans cet article, il traite de certaines difficultés qui surgissent lorsqu'il s'agit de coopération entre les AA et d'autres organismes intéressés au traitement des alcooliques. Entre autres, selon le Dr Aharan, les membres des AA affirment souvent que seul un alcoolique peut aider un autre alcoolique. A son avis, les alcooliques n'ont pas le monopole de la souffrance: c'est le lot commun de l'humanité. Il suggère également aux AA d'envisager la possibilité d'établir des centres de formation sur les relations humaines, afin de profiter de certaines des nouvelles découvertes dans ce domaine.

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BILL W.

The tall, spare, prophet-like figure of Bill W. no longer walks among us to guide and to inspire the fellowship he helped to found some 35 years ago. But the spirit of William Griffith Wilson, one-time Wall Street security analyst and alcoholic, will long continue to light the way for Alcoholics Anonymous, for its sister Al-Anon, and its offspring Alateen.

The Addiction Research Foundation of Ontario, like many another organization across North America and elsewhere that is helping to rehabilitate alcoholics and to prevent alcoholism, owes a great deal to AA (and without Bill Wilson there would have been no AA).

Individual AA members exerted a strong influence on the government of Ontario to take constructive action against alcoholism during the late 1940's; and this led to the passing of legislation in 1949 establishing the Alcoholism Research Foundation (later to become the Alcoholism and Drug Addiction Research Foundation, or less formally, the Addiction Research Foundation).

Since that time there have been many positive relationships between members of AA and staff of the A.R.F. We have helped each other many times in many ways. Above all, Bill

W. and his estimated 475,000 fellow AA members showed the world that alcoholism is not a hopeless condition, that recovered alcoholics can make great contributions to their fellows—alcoholic and non-alcoholic alike.

All of us owe a debt to Bill W. which we will only be able to discharge by following his powerfully human example in the way we deal with such far-reaching public health problems as alcoholism. Bill's precepts and AA's practical philosophy have many applications in this life that have nothing whatsoever to do with alcohol and alcoholism. We can continue to learn from him long after the day of his passing last January 24.

Thank you, Bill.

—R. R. R.



The Extent of Drug Use in Metropolitan Toronto Schools: A Study of Changes from 1968 to 1970

By Reginald G. Smart, Dianne Fejer, and Jim White

In January, 1968 a research group commissioned by the Addiction Research Foundation of Ontario and headed by Dr. R. G. Smart began a survey of drug use among Metropolitan Toronto students. Its purpose was to determine the extent to which various drugs—including hallucinogens (e.g., marijuana, LSD), psychoactive drugs (e.g., tranquillizers, barbiturates), tobacco, alcohol, and glue—were used by students in Grades 7, 9, 11, and 13; the students' attitudes toward and knowledge of these various drugs; and the differences in use, knowledge, and attitudes among various age and social groups. This was the largest and most comprehensive survey about drugs ever attempted among members of this age group, and its results soon became widely known. A resurvey of the same or similar school classes was undertaken two years later, in the first half of 1970, in order to determine whether drug use in general had increased and whether particular drugs were being used more or less frequently. A further aim was to see whether factors such as age, sex, religion, and language,

Dr. Smart is Associate Research Director (Evaluation Studies) at the Addiction Research Foundation, and Mrs. Fejer is Senior Research Assistant. Dr. White is Research Director, David Jackson and Associates, Psychologists, Toronto. The report on which this article is based is entitled *The Extent of Drug Use in Metropolitan Toronto Schools: A Study of Changes from 1968 to 1970*, and is available at \$3.00 a copy (plus 50 cents postage in Canada, \$1.00 elsewhere) from the Education Division, Addiction Research Foundation, 33 Russell Street, Toronto 179. The survey itself was planned by Dr. Smart and Mrs. Fejer, and the data were collected and analysed for the Foundation by David Jackson and Associates.

found to be important in 1968, were still associated in the same ways with drug use. In addition, the 1970 study investigated some new variables: drug use, knowledge, and attitudes in Grade 6; parental drug use; use of speed; and the relation of drug use to three aspects of a psychological state known as alienation which is often mentioned as a probable cause of drug use among young people. Finally, there was in the 1970 study, as in the 1968, an attempt to discover the causes of drug use by relating drug use among students to personal, parental, and social factors of many kinds.

Method

All the data in the 1970 study were obtained from a questionnaire completed by the students in their schools.

The sample included those classes (but not necessarily students) surveyed in 1968 plus a sample of Grade 6 students. In each school in which Grade 7, 9, 11, and 13 classes had been surveyed in 1968, the same number of classes was resurveyed. An attempt was made to return to the same class, but in 11 schools the class numbering system had been modified. In these, classes within each grade were randomly chosen.

In selecting the schools in 1968, classes were randomly selected at each grade level until 120 students in each grade in each high school district had been chosen. For purposes of the study, a high school district was taken to be a *high school attendance area* and to include the high school itself plus the various pre-secondary (e.g., junior high) schools that fed into it. In general, school districts were randomly selected within each borough.

Letters explaining the general purpose of the study and requesting permission for students to participate were sent to all parents. Where parents did not speak English, translations were provided.

The total number of students tested in 1968 was 6,447; in 1970 the total was 8,865. Of these, 1,932 were in Grade 6,

1,868 in Grade 7, 1,875 in Grade 9, 1,725 in Grade 11, and 1,422 in Grade 13. An additional 43 students did not indicate their grade.

The questionnaire was administered to 399 classes in 94 schools. In all cases, the students marked their answers on an optical scanning sheet—a form, separate from the questionnaire, which was later read by a machine called the optical scanner. They were instructed not to sign their names or put any identification on the questionnaire or the sheet. The questionnaire contained 82 questions, of which 58 asked for information on the following topics:

1. Demographic or statistical characteristics of the students and parents (e.g., age of student, birth place of parents);
2. Family characteristics;
3. Parents' drug use;
4. Students' personal drug use, knowledge about, and attitudes toward drugs; and
5. Students' social activities.

The remaining questions were items taken from the Dean Scale, a test developed in 1961 that has been shown to be a reliable and meaningful way of measuring three aspects of alienation that have been labelled powerlessness, normlessness (absence of values or conflict concerning values), and social isolation, and also of giving an overall measure of alienation.

Selected segments of the data were cross-tabulated for school district, grade, sex, drug use, parental drug use, family characteristics, and alienation. Comparisons were then made with the 1968 findings.

Results

Prevalence of Drug Use in 1968 and 1970

The pattern of drug use by students in 1970 differed from that found in 1968. For all drugs there was a statistically signi-

ficant difference between 1968 and 1970. Higher percentages of students reported using alcohol, marihuana, barbiturates, opiates, LSD, and other hallucinogens than in 1968. The percentage of students reporting use of tobacco was lower, however, as were the percentages reporting use of glue, stimulants, and tranquilizers.

The percentage of students using each drug in 1968 and 1970 is shown in Table 1. Since including Grade 6 students tended to reduce figures for all drugs except glue and solvents, drug use in 1970 is given in two ways: for Grades 7 to 13 only, and for Grades 6 to 13. By *drug use* is meant use of a drug *on one or more occasions* during the six-month period preceding the answering of the questionnaire. It is important to note that "use" in some cases indicates use on only one or two occasions and also that some use of drugs under doctors' orders is probably included.

When Grade 7 to 13 students in 1970 were compared with those surveyed in 1968, there was a doubling or more in the percentage of students using marihuana,¹ opiates, LSD, and other hallucinogens such as STP. The percentage of students using marihuana in 1970 was 18.3, as compared with 6.7 in 1968. Reported use of opiates also increased (from 1.9% to 4.0%), as did LSD (from 2.6% to 8.5%) and other hallucinogens (2.0% to 6.7%). Since data were not collected in 1968 for speed or for solvents other than glue, it is not known whether use of these increased or not. Use of alcohol—by far the most widely used drug—was reported by 60.2% of students in 1970, as compared with 46.3% in 1968. Some of this last increase may possibly be accounted for by a change in the phrasing of the alcohol question. In 1968, students were simply asked if they had used alcohol; in 1970, the questionnaire gave examples of drinks containing alcohol (e.g., wine, beer, whisky, gin, etc.). The percentage of students using tobacco dropped slightly, from 37.6% to 35.5%.

¹In both surveys, hashish and marihuana were grouped together under the name *marihuana*.

The use of psychoactive drugs, including barbiturates, stimulants, and tranquillizers, appeared to be relatively stable, although use of stimulants and tranquillizers had decreased slightly. The prevalence of illicit drug use had increased substantially. This included alcohol, marihuana, opiates, LSD, other hallucinogens, and speed. (Alcohol was included among illicit drugs because nearly all of the sample was under 20 years of age, while legal drinking age in Ontario is 21.)

TABLE 1

**Prevalance of Drug Use among Toronto Students
in 1968 and 1970**

	Percentage Using at Least Once in Last Six Months		
	1968	1970	1970
	Grades 7-13	Grades 7-13	Grades 6-13
Alcohol	46.3	60.2	53.1
Tobacco	37.6	35.5	30.4
Marihuana	6.7	18.3	14.5
Glue	5.7	3.8	4.1
Other solvents	*	6.3	7.2
Barbiturates	3.3	4.3	3.8
Opiates	1.9	4.0	3.5
Speed	*	4.5	4.1
Stimulants	7.3	6.7	5.8
Tranquillizers	9.5	8.8	7.6
LSD	2.6	8.5	7.2
Other hallucinogens	2.0	6.7	6.4
Total students	6,447	6,890	8,822

*Data not collected in 1968

Where a substantial increase in proportion of users was shown for a particular drug, there was also an appreciable increase in the frequency with which students were using that drug. For alcohol, marihuana, and LSD, the proportion of heavy users (students reporting using seven or more times during the preceding six months) was significantly greater than in 1968. The percentage of students reporting infrequent use (once or twice during the preceding six months) of marihuana doubled; the percentage reporting heavy use tripled. The relationship was the same for LSD and was even more evident in the case of alcohol, where infrequent use increased 14% and heavy use 41%. There was little change in the proportion of light and heavy users of tranquillizers, barbiturates, and stimulants, while tobacco and glue showed slight declines in proportion of heavy users.

For all drugs, there were significant variations among school districts in level of use. There also were noteworthy changes within some districts—e.g., one district in which eight times as large a percentage reported using marihuana as in 1968, another in which glue use declined from 13.3% to 4.8%.

Drug Use and School Grade

For solvents and glue, usage peaked at Grade 6 or 7, then decreased sharply. Alcohol was unique in that its use increased continuously from Grade 6 through 13. The percentage of students using each of the other drugs except stimulants increased from Grade 6 to 11, then decreased slightly at Grade 13.

A comparison with the 1968 data indicated that for most drugs peak use had shifted from Grade 9 to Grade 11, and that the increase in the prevalence of marihuana smoking involved primarily the students in Grades 11 and 13. The increase in the use of LSD and other hallucinogens was mainly in Grade 11 and the increase in the use of alcohol mainly in Grades 7 and 13. Grade 9 was chiefly responsible for the over-

all decrease in tobacco use. For other drugs, changes in prevalence were not concentrated in any one grade.

Sex, Age, and Other Factors

In general, a greater proportion of males than of females used drugs, and males used drugs more frequently than females. However, significantly more females used tranquillizers and there was no significant sex difference in the use of solvents, barbiturates, and stimulants. However, the rate of increase in the proportion of females using various drugs appeared to be higher than for males in the period 1968-70. For example, the percentage of females reporting marihuana use almost tripled (4.1% to 12.0%) while that of males doubled. The male rate of use was still higher at 16.9%, but the difference was becoming smaller. A similar pattern was observed for LSD, other hallucinogens, and alcohol. Much of the overall increase in drug use from 1968 to 1970 may be due to the higher rate of increase in drug use by female students.

The use of LSD in 1970 was related to the birth place of the father but not of the mother. The use of another seven drugs was related to the birth place of both parents. Alcohol use was most common among students whose parents were born in Eastern Europe and least common among those born in Asia, Africa, Australia, or South America. Students whose parents were born in North America were most likely to use tobacco, while children of Western European parents were least likely to do so. Marihuana was used by a higher proportion of students whose parents were born in Eastern Europe and the United Kingdom than in the other three areas.² (In 1968 the highest proportion of drug users [primarily marihuana users] was found among those students whose parents

²North America, Western Europe, and Other—Asia, Africa, Australia, and South America.

were born in the United Kingdom; however, in 1968 it was students with parents born in Eastern Europe who were *least* likely to use marihuana.) The pattern for LSD and other hallucinogens and stimulants was comparable. Children of parents born in Western Europe were least likely and those with parents born in the United Kingdom were most likely to use them.

For glue, opiates, speed, stimulants, and tranquillizers, a statistically significant relationship was not found between drug use and family religion. However, Jewish students and those with no religion were most likely to report use of marihuana and barbiturates. Jewish and Catholic students were most likely to report use of alcohol and tobacco. Those who claimed "Other" as their religion were least likely to use these drugs. Marihuana use was reported by 27.5% of Jewish students, 18.9% of those reporting no religion, 13.9% of Protestant students, and 13.5% of Catholic students. This was reasonably consistent with the results in 1968. In the earlier study, however, marihuana use was most common among students of no known religion and next most common among Jewish students.

For all drugs except opiates and "other solvents," a smaller proportion of students who lived with both parents reported using drugs than of students who lived with only one parent or someone else. The general pattern was for drug use to become more common as one moved from a situation in which the student lived with both parents to mother only, father only, living with sister, aunt, uncle, friend, or alone. However, the percentage of students using tranquillizers was higher for those living with their mothers only (11.6%) than for those living with their fathers only (10.0%) or both parents (7.0%). This pattern is consistent with that found in 1968. It would suggest that the more stable their home environment the less likely students are to be drug users.

For alcohol, marihuana, opiates, barbiturates, stimulants, LSD, and other hallucinogens, a relationship was found be-

tween student use and the type of job held by the father. The children of professionals were more likely to use drugs than students whose fathers were proprietors, or skilled, semi-skilled, or clerical workers. This relationship was most evident for alcohol, marihuana, opiates, and LSD. In addition, children of professionals reported using drugs most frequently.

Here again, 1968 and 1970 patterns were, in general, very close to one another. However, there did not appear to be a continuous pattern from 1968 to 1970 when it came to the question of parental working hours (whether parents worked daytime, shifts, part-time, or were unemployed). The only trend that did emerge in this general area was a tendency among students to use alcohol, tobacco, glue, other solvents, and hallucinogens other than LSD which increased as one considered students whose mothers did not work, worked part-time, worked days, and worked shifts. The findings suggested that drug use was related to the degree of disruption within the home produced by the mother's work. (In 1968 there was no significant relationship between mothers' working hours and drug use by their children.)

Sibling Use of Drugs

Student use of all 12 drugs covered by the study was significantly related to reported use of marihuana and/or glue by brothers and sisters. A cumulative effect was observed for nine of the drugs studied. If his sibling was reported as using both marihuana and glue, a student was more likely to use barbiturates, glue, other solvents, opiates, speed, stimulants, tranquillizers, LSD, and other hallucinogens, than if his sibling only used one (marihuana or glue). Students who said their siblings used only marihuana were more likely to use alcohol, tobacco, and marihuana than those whose siblings used glue or glue and marihuana. If siblings did not use either marihuana or glue, the student was less likely to use any of the drugs. These results were consistent with 1968 findings.

Parental Drug Use, Student Use, and School Grades

Estimates of parental use of alcohol, tobacco, stimulants, tranquillizers, and barbiturates were acquired from the students. The data indicated that students were more likely to drink alcohol than their mothers but less likely to do so than their fathers. Tobacco and barbiturates were used by a larger percentage of both mothers and fathers than sons or daughters. Fathers were relatively less likely to use stimulants than any of the other drugs; mothers were more likely to use tranquillizers. The use of alcohol and tobacco appeared to be male-linked while tranquillizer use was female-linked—that is, more women and girls use tranquillizers than do men and boys, and more men and boys use alcohol and tobacco than do women and girls. In general, students were least likely to use drugs if their mothers used neither tobacco nor alcohol and most likely to use drugs if their mothers used both tobacco and alcohol. The use of either tobacco or alcohol—especially the latter—by mothers was associated with student drug use, with the association being strongest where mothers used both. Mothers' use of tobacco was more often associated with student use of glue and other solvents than mothers' use of alcohol.

Mothers' and fathers' use of tranquillizers, stimulants, and barbiturates was cross-tabulated with students' use of 12 drugs. For all 12, a statistically significant relationship was found which indicated that when parents were frequent users of any of these drugs, their children tended to be drug users. When parents were infrequent users or non-users of tranquillizers, stimulants, or barbiturates, their children were usually non-users of drugs generally.

A significant relationship was found between overall subject average in school and use of all 12 drugs. For all except alcohol and tobacco, the tendency toward use and the frequency of use decreased as the student's subject average increased. The same pattern was found in 1968. It was impossible to de-

termine whether the use of drugs produced lower grades or whether students who tended to get lower grades were predisposed to be heavy drug users.

Drugs and Activities

As in 1968, the percentage of students using most of the drugs decreased as participation in school activities increased. The use of glue and other solvents followed a different pattern, however, with the students who participated in three (out of a possible four or more) activities being the most likely to report using these drugs.

Students who reported spending their weekday evenings in organized activities were the least likely to use drugs, while those who hung around with friends were most likely to do so. Most drugs followed the same pattern as was observed with marihuana. This drug was used by 8.7% of students who engaged in organized activities, 10.8% of those who stayed at home, 20.2% of those who visited friends, and 26.6% of those who hung around with a group. Such relationships followed a similar pattern in 1968.

Students who generally stayed home on weekends were least likely to use drugs, while those who went out and hung around with a group, went to parties, dances, etc., were most likely to do so. Those who spent their weekends at a friend's house or went out with friends were intermediate. Generally, the more time a student spent in unsupervised activities, the more likely he was to use drugs.

Acquaintance with Suppliers

Half the students reported they did not know anyone who would give or sell them marihuana; 20% knew one to three suppliers; 29% knew four or more. It is interesting that, as in 1968, *use of all 12 drugs* was positively related to number of *marihuana* suppliers known.

Reasons for Not Using Drugs

The major reason given for not using drugs was danger to health. Forty-one per cent chose this reply, as compared with 32% who indicated they preferred other activities. Two per cent were concerned because use of some drugs is illegal, 3% were influenced by parental disapproval, and 8.0% indicated drug use. The remaining 14% did not reply to this question. The major factors influencing students to use or not to use drugs were information received from television, books, or newspapers (39%) and what friends told them about drugs (21.0%). The information sources which provided the most influence on the decision to use drugs were also listed by students as the sources from which they learned most about drugs. Forty-two per cent of the students learned most of what they knew about drugs from the news media and 25% from friends. These findings were consistent with those of 1968.

When Drugs First Used

Half the students who had used glue reported they first sniffed in 1969 or 1970. The other half had sniffed earlier. The comparable data for marihuana indicated almost two-thirds of the users first used it in 1969 or 1970. It was hard to estimate whether more students were starting to use these drugs because only four months had elapsed in 1970 when the data were collected.

Parental Awareness of Drug Use

Three-quarters of the students who used marihuana, two-thirds of those who used glue, but only 28% of those who used alcohol believed their parents did not know they did so. Almost half the students who used alcohol claimed their

parents approved, while only 5% and 7% respectively of marihuana and glue users reported parental approval.

Overall Analysis

Overall analysis of the data showed that 38.2% of students used none of the 12 drugs and 74.1% used none of the 12 other than alcohol and tobacco. Of the students—about one-quarter of the sample—who reported using psychoactive drugs (tranquillizers, barbiturates, or stimulants) and/or illicit drugs (in this case marihuana, LSD, other hallucinogens, speed, opiates, glue, or other solvents), a higher proportion were using illicit drugs than in 1968. In that year, 53.2% of these students were using illicit drugs while 46.8% were using psychoactive drugs but no illicit drugs. In 1970, the proportions had changed to 83.1% and 16.9% respectively. It is also interesting to note that the majority of psychoactive drug users were taking only one psychoactive drug, primarily tranquilizers, while the majority of illicit drug users were taking a combination of illicit drugs.

Multiple Drug Use

An effort was also made to determine relationships between the use of particular drugs and the use of other drugs. Many glue users also used other solvents, and glue use was also closely related to use of speed and stimulants. The use of other solvents was moderately related to the use of barbiturates, speed, stimulants, and opiates, and the use of these four drugs was highly interrelated. Marihuana, the most commonly used drug after alcohol and tobacco, was more closely associated with LSD than any other drug, and alcohol and tobacco were closely associated both with marihuana and with each other. Among student drug users there appeared to be three sub-groups: those who used alcohol, tobacco, and marihuana;

those who used glue and other solvents; and those who used barbiturates, opiates, speed, and stimulants.

Alienation and Drug Use

Data concerning alienation covers only Grades 9, 11, and 13, since the Alienation Scale's terms and concepts proved to be beyond the grasp of Grade 6 and 7 students.

The concept of alienation, as used in this study, describes a syndrome made up of three components: powerlessness, social isolation, and normlessness. Powerlessness implies a feeling of lack of control over the environment. Social isolation includes feelings of separation from the group and/or isolation from group standards. Normlessness has two dimensions. The first involves absence of or loss of values—that is, of ideas giving direction to life. The second involves a conflict in values. The individual, here, has no standard upon which he can base his behavior since the norms to which he tries to respond are in conflict.

A significant relationship was found between normlessness scores and the use of all 12 drugs, and between overall alienation and the use of all drugs except speed. Powerlessness was related to the use of all drugs except opiates, speed, and LSD. Social isolation was related to only half of the drugs, namely alcohol, tobacco, glue, other solvents, barbiturates, and tranquilizers.

Drug use appeared to be most consistently related to normlessness. Those students whose norms are consistent with those of their parents and the so-called "straight world" are less likely to use drugs than other students. The use of drugs, therefore, may be part of a search for identity and meaningful norms, and students under pressure from conflicting norms may use some drugs as an escape.

While many students with a high sense of social isolation used drugs such as alcohol and tranquilizers which are accepted in the adult world, most users of marihuana, opiates,

speed, stimulants, LSD, and other hallucinogens did not feel isolated, perhaps because they were members of a "drug sub-culture."

Powerlessness was associated with the use of all drugs other than opiates, LSD, and speed. Apparently the users of most drugs tend to seek in them for feelings of power which would otherwise be lacking. This is particularly true of the way in which alcohol is sometimes used—to give people "strength" and "courage" to face difficult situations.

While drug use tended to be positively related to alienation, the relationship was not always consistent. Generally, alienation increased as frequency of drug use increased but then decreased among heavy drug users. In effect, the heavy users tended to be less alienated than the moderate users.

Finally, student alienation scores (on all four scales) were positively related to parental use of psychoactive drugs. Students whose parents used tranquillizers, stimulants, or barbiturates were more likely to be alienated than students whose parents did not. In addition, students who reported that their fathers used both alcohol and tobacco were more normless than those whose fathers used neither or used just one. Students whose mothers drank alcohol and smoked tobacco were more socially isolated and more alienated generally than those whose mothers used neither or just one. The direction of causality could not be determined.

Discussion

It is clear that heavy use of illicit drugs increased over the period studied. If the present rate of increase continues it will take only four years until marihuana is used by more students than was alcohol at the time of the second survey. Statistically it would take less than six years at the 1968-70 rate of increase to reach a point at which all have tried marihuana.

The 1970 data shows a peaking of drug use at Grade 11 instead of at Grade 9, as was the case in 1968. This does not

necessarily mean that the crest of a wave is passing into higher and higher grades, ultimately to disappear. The percentage of students using illicit drugs was higher both in Grade 9 and in Grade 11 in 1970 than in 1968 in any grade, and the use of illicit drugs was higher in all grades in 1970 than in 1968.

It is clear from findings on alienation that counter cultures associated with drug use have developed. The relationship between parental drug use and alienation is also important. Which factors come first in time sequence is a matter for further research.

The implications of the above findings for drug education are fairly clear. First, it is obvious that methods for preventing a continued growth in the use of illicit drugs are yet to be discovered. Although considerable drug education was undertaken in Toronto schools in the two years between surveys, it did not reduce use of most illicit drugs. (Perhaps it helped to decrease use of tobacco and glue, although the program did not focus on these drugs.) Experimentation in new methods of drug education is certainly needed, as are additional studies of the trends in adolescent drug use.

The relationship between parental drug use and alienation suggests that the development of drug education programs will have to take into account the interplay between parental drug use, student alienation, and student drug use. Such programs will also have to involve parents to a much greater extent than they have so far.

More generally, the study shows that current adolescent drug use is related to drug use in the larger society and to aspects of adult behavior. Efforts to concentrate drug abuse prevention and control measures on young persons alone will probably be ineffective.

Cet exposé porte sur un deuxième sondage effectué en 1970 dans 399 classes de 94 écoles situées dans les limites de l'agglomération torontoise. On y a interrogé 8,865 élèves de 6ième, 7ième, 9ième, 11ième et 13ième année pour savoir s'ils faisaient usage ou non de 12 drogues différentes, quelles étaient leurs opinions et leurs connaissances au sujet des drogues, et pour obtenir un certain nombre de renseignements démographiques et sociaux sur les étudiants eux-mêmes et sur leurs familles. Comme la plupart des questions avaient déjà été posées en 1968 dans les mêmes classes ou dans les classes semblables de 7ième, 9ième, 11ième et 13ième année, on a pu établir des comparaisons entre les renseignements recueillis en 1968 et une grande partie de ceux obtenus en 1970.

En 1970, un plus grand nombre d'étudiants qu'en 1968 ont révélé qu'ils faisaient usage d'alcool, de marijuana, de barbituriques, d'opiacés, de LSD et d'autres hallucinogènes. Le pourcentage d'étudiants faisant usage de tabac, de colle, de stimulants et de tranquillisants a diminué. La proportion des grands usagers d'alcool, de marijuana et de LSD a augmenté en 1970. Entre 1968 et 1970, l'usage le plus fréquent de la plupart des drogues, qui avait été remarqué d'abord en 9ième année, est devenu le fait de la 11ième année, et la proportion des usagers a augmenté de façon plus marquée chez les filles que chez les garçons.

L'usage des drogues chez les étudiants a été, en général, positivement relié à l'insuccès scolaire, au manque de participation aux activités scolaires et autres activités organisées, à la connaissance d'un plus grand nombre de trafiquants de marijuana, et à un sentiment de désaffection, y compris un manque de convictions, c'est-à-dire l'absence de sens des valeurs, ou de conflit concernant ces valeurs. On a aussi relié positivement l'usage des drogues chez les étudiants à l'usage que faisaient leurs frères et soeurs de marijuana et de colle, ainsi qu'à l'usage que faisaient leurs parents de drogues psychoactives (barbituriques, tranquillisants, stimulants), d'alcool et de tabac. Des sentiments de désaffection chez les étudiants sont aussi reliés à l'usage de drogues psychoactives, d'alcool et de tabac chez leurs parents.

Le sondage de 1970 a été préparé par Reginald G. Smart et Dianne Fejer de la Fondation de la recherche sur les toxicomanies (Addiction Research Foundation). Les données ont été recueillies et analysées par la maison David Jackson and Associates.

Marihuana, the Experts, and the Public

By Oriana Josseau Kalant

The current widespread illegal use of mind- and mood-modifying drugs, of which cannabis is perhaps the most important example, has posed a number of questions and problems for the public as well as for special groups such as government, educators, the medical and legal professions, parents, and marihuana users themselves. Understandably, the public has turned for the answers to those whom it assumes to be experts, or to those who volunteer themselves as experts, expecting a body of sound and consistent answers which it has so far failed to obtain. This has led to a state of confusion and frustration expressed, at least partly, as disappointment or even hostility toward the experts. Such feelings are illustrated by the often repeated phrases "so-called experts," or "self-appointed experts" and statements such as "the experts cannot even agree among themselves."

Because a scientifically sound and socially satisfactory resolution of the marihuana controversy will inevitably require co-operation among experts, as well as between experts and society at large, it might prove useful to examine objectively the question of who qualifies as a competent and trustworthy expert on marihuana.

Ideally, it may help the various specialists to define more precisely their own areas of competence, the public to adopt a more selective and critical attitude toward the statements and judgments of the specialists, and the communications media

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to meet more effectively their responsibility in acting as intermediaries between the other two.

The marihuana question is only one of a large variety of social issues in which it is important to recognize the difference between matters of fact and value judgments or emotional reactions to these facts. A specialist may become expert in a particular category of facts, but in his emotional reactions to them he is basically no different from the general public. For example, a nuclear physicist may know in great detail how a hydrogen bomb works and what effects its explosion can cause, but given the same facts he is no more expert than any concerned citizen in deciding whether nuclear warfare is good or evil.

Confronted with a topic that arouses strong reactions, the specialist may experience great difficulty in separating his own feelings and ethical attitudes from his factual knowledge. If he succeeds in isolating or compartmentalizing these two areas of his mental processes he achieves objectivity, or the ability to transmit knowledge to others dispassionately and without moral overtones. If he does not succeed he will necessarily introduce distortions, from the most gross to the most subtle, which satisfy his own emotional needs, even though he may still honestly believe himself to be objective.

These attitudes, which are partly conscious and partly unconscious have, in the case of marihuana, historical roots. The specialist who becomes interested in the subject does not approach it innocently or afresh. He brings to it a series of notions that he acquired automatically, and most likely uncritically, in the process of becoming educated. He has learned, for example, that the drug is illegal and that the law defines it as a narcotic together with the opiates. This will have at most the implication that the drug is addictive and that its use is associated with criminal or deviant behavior, and at least, that because it is illegal it is more dangerous than other drugs that are not, such as the amphetamines until recently.

As he becomes more acquainted with the subject he soon finds that the legal definition is pharmacologically unsound and that, in fact, the actions of marihuana are quite different from those of the opiates. This means that the process of learning about marihuana simultaneously involves the much more difficult and opposite process of unlearning preconceptions about it, including some that have emotional overtones (e.g., fear of physical dependence), and value judgments (e.g., since this drug is used by members of alien cultures, it is suspect). Therefore he must unlearn not only intellectually, which is relatively easy, but also emotionally or ethically, which is much more difficult.

There has been much less difficulty in accepting the pharmacological reclassification of marihuana as an hallucinogen than there has been about changing its legal status in keeping with its properties. But the problem is very rarely stated in these terms. Since reasoning seems to be a much more acceptable method of persuasion than feeling, the emotional attitudes are often submitted to a more or less elaborate process of rationalization. The expert on cannabis, regardless of his specialty, is at least as prone to doing this as anyone else and often much more so. The reason is that he is under constant pressure from the rest of society to make pronouncements on the subject which require not just communication of data but interpretation and judgment of their social significance. This may lead him to express ideas which under other circumstances he may entertain not at all or only as conjectures or hypotheses. But the onus is on him to become aware of where his command of objective facts ends and his emotional bias begins. Ideally, in his public role as expert, he should limit himself to being factual, while as an individual citizen he is entitled to express his feelings as he chooses.

This failure to differentiate adequately between fact and bias is just as common among those experts who favor a change in the marihuana laws as among those who favor the

status quo. The writings and speeches of highly articulate and intelligent advocates of legalization of marihuana contain many examples of arguments in which they have used facts which favor their case while ignoring other equally important facts *contained in the same sources* which undermine their position.

Another factor that contributes significantly to the confusion in the public mind about the credibility of experts is the multifaceted nature of the topic. The subject of marihuana does not fall entirely within the confines of any one specialty. On the contrary, it cuts across the borders of a wide variety of disciplines. Botanists who have made a special study of the hemp plant may become experts in its cultivation or in factors which affect its content of active ingredients. Organic chemists may become experts in the complex chemical structure of these ingredients. The specialists who study the effects of these chemicals on the body and on behavior are regarded as experts on the pharmacology and psychology of marihuana. There are expert sociologists and anthropologists whose fields of observation and study are the social and cultural features of cannabis use, and medical men and psychiatrists who concentrate on the connection between marihuana use and physical and mental illness. But the topic reaches beyond the confines of science. Government is involved in the sense that it has forbidden the use of the substance and, as a result, there are specialized agencies of government and of law enforcement which develop experts on these facets of the issue. Again, those lawyers who choose to concentrate on legal cases involving marihuana charges may become particularly familiar with the issues and social consequences of the law, and thus experts in these matters. Educators, social workers, or clergymen may become experts on the social and moral aspects of the question. And lastly there are the users themselves, who feel they are more knowledgeable than non-users concerning the effects of marihuana and who also develop a great deal of

expertise in the art of procuring and using the drug and of avoiding the penalties imposed by the law.

It should be self-evident that no one individual could possibly be equally expert in all these areas of knowledge. This can only be achieved by interdisciplinary groups or institutions which include among their ranks representatives from most or all of these fields of knowledge who have familiarized themselves with special knowledge about marihuana. The Addiction Research Foundation is an example of such a group.

The problem, however, in the relationship between the experts and the public arises from the assumption that any one of the specialists listed above is not only objective, competent, and knowledgeable in his own field but in many or all of the others. Thus the expert cannabis chemist may be called upon, or take it upon himself, to expound his views on the biological and social effects of marihuana, the pharmacologist on the psychiatric complications of marihuana use, the psychiatrist on the soundness of the law, or the policeman on the behavioral effects of the drug. The public, having no means of distinguishing between these various areas of expertise, may attach equal value to everything the individual expert says and the latter, under internal or external pressure to come up with answers, may forget the limits of his own competence. This is not to imply, of course, that there are no individuals who achieve a great deal of comprehensive and sound knowledge in a variety of fields, but they are the exception rather than the rule. In addition to all these considerations there is in this field, as in any other, the factor of quality. Familiarity with the field does not necessarily guarantee competence and sound judgment, and thus there are good, bad, and indifferent experts.

Since a great deal of information on this topic reaches the public indirectly through the communications media, rather than by direct contact with the experts through their writings and lectures, a double process of selection also affects their

relationship. In the first place, as a rule the specialist does not volunteer his information to the media; rather, the media select individual specialists to ask for information or opinions. This process of selection is more often than not based on availability rather than on qualifications. Some highly competent and specially trained journalists, both in the press and other media, do an excellent job of sifting their sources of information. However, much reporting of news items related to the drug question is done by people without special training of this type. Therefore, even assuming that they were aware of all the considerations discussed above, they have no special knowledge of the population of experts in any particular area and select more or less haphazardly those that for one reason or another are known to them. Thus the question of qualifications is left largely to chance. Finally, the selected expert may or may not be willing to co-operate, depending on his personality, on his previous experience with the media, and on a variety of other considerations. This introduces another element of fortuitousness into the process.

The second element of selection that influences markedly the final product that reaches the public is the editorial process performed by the media. When the statements of the expert reach the public indirectly, they have been modified both by the ability of the reporter to understand what the expert has said, and by his own biases and preconceptions. Further selection occurs on the basis of editorial judgments concerning the news value of different items. An important scientific concept may not be considered as newsworthy as an unfounded opinion expressed by a well-known personality.

The end result of all this is that the public is confronted with an array of information which may be correct or incorrect, objective, subtly distorted, or frankly biased. Having been told that it all stems from authoritative sources or experts, the public can only conclude that the latter do not really know very much about the subject, while in fact some do and some do not.

The quality of the marihuana debate, and the soundness of the decisions eventually taken, will depend therefore on the degree to which all concerned are aware of their respective responsibilities and areas of expertise. The specialists have an obligation to distinguish between their factual knowledge and their value judgments and to co-operate constructively with the media. The public, on the other hand, has the responsibility of making use of those sources of direct information which are already available (such as the fact sheets provided by the Addiction Research Foundation) and of developing a critical attitude toward the information it receives through the communications media. But the highest responsibility of all lies with the latter. This is so because they are the intermediaries between the experts and the public, because they not only report but interpret the information provided by the experts, because they alone select the information, and finally and most importantly because they exert enormous influence by their ability to reach vast audiences. This last point applies particularly to television. Yet this medium has the least consistency of policy in differentiating between entertainment and public responsibility.

Two important contributions that the media could make would be the formulation of a clear code concerning the balance between their educational role and their news or entertainment function, and greater reliance on highly trained expert journalists specializing in scientific matters such as those who write for some of the major newspapers.

Dr. Kalant, qui fait des recherches à l'Addiction Research Foundation à Toronto, examine la question de savoir qui mérite d'être qualifié en tant qu'expert sur la marijuana et quels sont les facteurs qui

contribuent à la confusion du public quand ce dernier cherche à déterminer les vrais experts sur la marijuana. Les experts ont peut-être des difficultés à séparer leurs connaissances objectives d'avec leurs sentiments et leurs attitudes subjectives; des spécialistes (médecins, avocats, et sociologues, par exemple) peuvent être appelés à donner leur avis sur certains aspects de la toxicomanie qui sont totalement en dehors du domaine de leurs connaissances. De plus, la familiarité avec un certain domaine n'est pas une garantie de compétence — il y a des bons experts, de mauvais experts et des experts quelconques. Des problèmes surgissent aussi parce que les informations n'atteignent pas le public directement; les média d'information peuvent ne pas choisir les meilleurs experts dans ce domaine, ou encore modifier le sens des déclarations des experts.

Dr. Kalant recommande aux spécialistes de définir de façon plus précise leur champ de compétence, et suggère au public d'adopter une attitude plus sélective et plus critique envers les déclarations et les jugements des spécialistes. Enfin, elle conseille aux média d'information de s'acquitter de façon plus efficace de leurs responsabilités en servant d'intermédiaires entre les spécialistes et le public.

Illusionogenic Crisis and Effective Intervention

By Wally Seccombe

When a young person arrives at a drop-in centre, a hospital, or the medical tent at a rock festival suffering ill effects from taking an illusionogenic¹ drug, he presents a problem in treatment that ideally would engage the skills of three different professionals. A youth worker would make initial contact with the tripper, develop rapport, alleviate anxiety, and attempt to ascertain, from his knowledge of the street culture, what drug the youth had taken. A medical doctor would perform an examination to assess the general physical health of the youth and to determine if the drug taken, given the dose and quality, would be dangerous physiologically. A psychiatrist would assess the tripper's general mental state, noting behavior and thought patterns that would indicate severe disturbances. He might elect to intervene verbally or administer a therapeutic drug.

Unfortunately, few individuals can integrate all three roles or perform them simultaneously. The psychiatrist has a medical training, but few physicians or psychiatrists have the youth worker's knowledge of the street culture or the visual and verbal style so crucial in evoking trust in a confused, anxious youth. As a result, neither the medical doctor nor the

Wally Seccombe is a youth worker for 12 Madison, an agency jointly sponsored by the Addiction Research Foundation and the YMCA.

¹ The term illusionogenic is used in preference to hallucinogenic because hallucinations are not characteristic of most trips on drugs such as LSD, STP (DOM), DMT, mescaline, psilocybin, MDA, and related compounds.

psychiatrist finds it easy to gain enough acceptance to perform his role satisfactorily. Consequently, intervention falls to the youth worker, who must have sufficient medical and psychiatric first-aid skills to perform primary intervention and to know when to call on the doctor or the psychiatrist to support his intervention or to assume full responsibility for continuation of treatment. This paper will describe some symptoms which commonly appear during bad trips and will outline some of the youth worker's most effective methods of intervention.²

It is impossible accurately to estimate the proportion of illusionogenic trips that would be described by subjects as "bad." Most trippers report occasional bad moments on many of their trips but describe relatively few trips as totally bad experiences. However, the jargon of the drug culture usefully distinguishes two types of bad trips—the "bummer" and the "freakout." A "bummer" is a state of anxiety and discomfort of a mild to moderate nature, while a "freakout" is a more severe state of anxiety and mental disruption. Bumpers are much more common than full freakouts. Freakouts, in fact, comprise a very small proportion of all trips.

The experienced worker can usually assess the gravity of a bad trip in a matter of minutes. I look for two key symptoms: dislocation and anxiety or fear. I make a rough estimate of the severity of these factors by placing them on a continuum from normal through moderate to severe.

The Dislocation Continuum

A person in a drug-free state makes a continuous and fairly successful attempt to "locate" himself physically, psychologically, and socially. Physically, he is able to perceive and to judge distance, shape, color, angle, proportion, and move-

² Discussion of drug overdose, toxic impurities, and appropriate medical intervention in such cases has been omitted.

ment. Psychologically, he integrates thought and feeling and is able to control most aspects of his behavior to the extent that he copes reasonably well in daily life. Socially, he is able to perceive and roughly to judge the behavior of others, particularly as it relates to himself. He is able, therefore, to stabilize his relationships with others sufficiently well to cope with the events of a normal day.

Under the influence of an illusionogenic drug, a subject's ability to "locate" himself may be interrupted, impaired, or distorted. The degree of his impairment places a tripper somewhere on a *dislocation continuum* ranging from mild to severe. His dislocation will generally occur in all three realms: physical, psychological, and social.

A person who is mildly dislocated may stagger as he navigates precariously across a room, constantly reassessing shapes and distances. He may appear confused; his thoughts may be wandering and random; he may be doubtful of his own feelings about himself, and socially ambivalent in that he is dubious about the reality or sincerity of another person's professed intentions and feelings. The drug culture terms this state a bummer.

A severely dislocated person experiences complete fragmentation and disruption in all three realms. Physically, his perceptions are in complete chaos; for example, he may see walls and floors moving, melting, or breaking up. Psychologically, his thoughts are bizarre and disjointed; he often talks in staccato associative bursts, indicating that he has lost the ability to distinguish between internal experiences and external reality. In the social realm, he may be very paranoid. On the other hand, he may be so confused or withdrawn as to be unable to relate at all to another person. This is the full freakout.

I have described two positions on the dislocation continuum, but it should be stressed that the tripper may take any position on the continuum and that he may move either way in a relatively short period of time.

Anxiety and Fear Continuum

The literature on human behavior distinguishes between anxiety and fear by referring to anxiety as a generalized state while regarding fear as an emotion focussed on a specific source. Both fear and anxiety are characteristic of illusionogenic crises; the tripper's emotional state may or may not be directed to a specific object. Hereafter both states will be included in the term *anxiety*. Anxiety is familiar to most people and needs no lengthy explanation. However, the extreme position on this continuum, that of sheer terror, is a rare experience.

People in a drug-free state generally have fairly useful ways of alleviating their anxiety. They may avoid or withdraw from undue risk or danger. They may redirect their attention to new situations or thoughts that are more pleasant; they may try to suppress nervousness, to remain calm, and to think through immediate problems that cannot be avoided. They may call on friends or authorities for support.

Under the influence of illusionogenic drugs, some or all of these responses may not be appropriate or even possible. Thoughts that produce anxiety may continually recur and attention may be difficult to redirect. Logical thought may be impossible; will power may vanish, friends and authorities may be useless, inaccessible, or regarded as dangerous. Under these conditions, it is likely that anxiety will rise very rapidly.

The Interrelation of Dislocation and Anxiety or Fear

As dislocation increases, the level of anxiety or fear rises. The cause and effect relationship of these two factors seems to be reciprocal. In some cases, it appears that dislocation resulting from the effects of the drug induces anxiety arising from a loss of the familiar. This anxiety may be accompanied by a fear of permanent loss of sanity. In other instances, anxiety that is picked up from friends or that results from a

sudden or recurring thought may appear before dislocation becomes significant. This "drops the floor out from under the tripper's feet," and in his futile effort to grapple with anxiety he accentuates his own dislocation. In most bad trips, the degree of severity of the two factors appears to be linked; however, occasional cases of severe dislocation have been encountered in the apparent absence of severe anxiety or fear.

Effective Intervention

I have isolated anxiety and dislocation as being important factors in bad trips. Having assessed these two factors, the worker intervenes to help the tripper reduce his anxiety and to provide location at the tripper's request. If he can accomplish these two tasks, he has made an effective intervention. An acute crisis will be alleviated or averted, and the remainder of the trip may even become a relatively pleasant experience.

Reduction of Anxiety or Fear

Ideally, the worker makes contact with the tripper in a comfortable, uncluttered, and stable environment with soft lighting and informal furniture. The room should be fairly quiet and have little pedestrian traffic. The worker, attentive but not alarmed, is a calm and reassuring presence. He encourages the tripper to be patient and comments that the drug's effect, which may now be pronounced, will diminish with time and that he will return to normal in a few hours. These simple reassurances are helpful in relieving anxiety.

Most drug users identify with a particular cultural form involving rock music, a shared stance on social and political issues, and an interest in particular life styles and communities. The tripper often recognizes an ally in the worker if their casual conversation implicitly acknowledges this common cultural form. Such recognition allows the rapid develop-

ment of rapport and trust and, consequently, the reduction of anxiety.

Particularly when he is with a tripper in a mild to moderate anxiety state, it is useful for the worker to act as a listener while the tripper talks on and on. Occasional empathetic nods and gestures provide assurance and relief and the tripper, in effect, talks himself down. The worker makes no direct entry into the trip at all.

If the tripper is at ease with casual physical contact and does not misconstrue it as a sexual advance, the worker may slowly massage the back, shoulders, neck, and temples of the tripper, easing his tension, imparting affection and support, and focussing the tripper's attention on the physical realm when the mental realm is causing discomfort.

When a tripper is in a state of severe dislocation and withdrawal and verbal intervention is useless, touch becomes increasingly important. Eye contact is also very important because trippers, often uncertain of another person's sincerity, may watch every eye movement and facial expression for reassurance.

Providing Location in the Physical Realm

People in a drug-free state continually strive to locate themselves precisely in the physical, psychological, and social realms. They learn to cope with disorientation by making renewed efforts to focus concentration. Since such attempts are often futile for a person under the influence of illusionogenic drugs, a supreme effort to relocate—"to put one's feet on the ground"—merely raises anxiety and contributes to a preoccupation with loss of sanity. The worker's role is, therefore, to assure the tripper that dislocation is a standard illusionary state, as normal on a trip as orientation is in a drug-free state.

The worker assures the tripper that return to a normal state takes time but is practically inevitable. He also encourages the

tripper not to make a concerted attempt to force concentration and control. The worker may find it necessary to repeat this advice—"relax, let it flow, don't try to put it all together now, just let it go." The worker clarifies external reality for the tripper with reminders of time and space and simple, straightforward comments on appearance and behavior. Because the tripper's memory is often impaired, it may be necessary to repeat these, in updated form, from time to time on request. In this way the tripper is free to "let it flow," to accept the temporary lack of congruence between internal and external realities, and to use the worker to provide location in the physical realm. Touching can provide location as well as relieve anxiety and is particularly important in a severe crisis when the tripper is beyond the reach of verbal intervention.

Providing Location in Other Realms

Objective location is difficult for the worker to provide in the psychological and social realms. However, the tripper can often be gently dissuaded from trying to discover the meaning of everything immediately. He can generally be persuaded to accept a lack of clarity and to surrender the need for black-and-white understanding. The worker comments that after the trip some stable perspectives will be possible. Much of our daily thought structure is static, linear, and logical; such thought is very difficult under the influence of an illusionogenic drug. Fear of dislocation can be relieved if the worker suggests to the tripper that he should accept more dynamic associative thought patterns as temporary alternatives.

When rapport has been developed, the worker's responsive attention provides a degree of location in the social realm that might be jeopardized if his role were transferred to a new person. For this reason, it is generally wise for one worker to remain with the tripper through the acute stages of the crisis. In the later stages, when the tripper is "coming down" satisfactorily and the worker is tired, it is usually not too

difficult to transfer the worker's role gradually to a new person.

Dealing with the Content of the Trip

The content of an illusional experience reflects the tripper's level of maturity, awareness, and basic concerns, as well as a multitude of other factors. In dealing with the content of a trip, I find it useful to distinguish types or levels of content. Superficial situational content (e.g., "Will you tell my parents?" or "What happened to my friend who dropped the other tab?") can be dealt with in a straightforward manner, usually to the relief of the tripper. Psychological or existential material may also arise (e.g., "Why! Why! It's all so unreal.") and must be handled differently.

It is possible to provide affirmation and location for the tripper without probing the deeper psychological or existential levels of the experience. The worker himself must be able clearly to distinguish between superficial and depth material in order to intervene effectively in the illusionogenic crisis.

People who allow their own needs to obscure this distinction by assuming the psychoanalyst or guru role should not be performing crisis intervention. Even mature workers with experience in handling bad trips may occasionally find themselves "getting in over their heads," usually to the detriment of the tripper.

Chemical Intervention

I will distinguish two types of chemical intervention and discuss them separately. The first involves the use of small doses of a tranquillizer (5 to 10 mgs of diazepam [Valium]) given orally to accomplish a degree of muscle relaxation and anxiety reduction. This does not abort the trip but may assist the tripper in his efforts to cope with his anxiety. In many cases, there appears to be more reduction of anxiety than can

be attributed to the tranquillizer alone. In such cases, it is likely that a placebo effect is operating.

Although it is helpful, the use of tranquillizers has drawbacks. In an age of drug dependence, people resort too readily to taking drugs as a means of coping with their difficulties. One goes up with one pill and, if it is a bit uncool, one comes down with another. This attitude is very prevalent among members of the drug culture, and the worker should not encourage that dependence. A second drawback of administering tranquillizers is that too large an oral dose may affect motor activity to the extent that the tripper experiences difficulty with physical co-ordination. He may attribute this incorrectly to the illusionogen. This raises the anxiety level and consequently gets in the way of the worker's efforts.

Workers often encounter difficulty in their initial contacts with trippers because many have come to expect (and even demand) "downers" for all mildly unpleasant effects experienced when tripping. Their unrealistic expectation sets them up for a disappointment when a request for tranquillizers is refused. Youth workers should try to develop a consistent position on tranquillizers that can be explained to young people. The tripper is less likely to feel personally rejected if a refusal to give him tranquillizers is accompanied by such an explanation.

Another more serious type of chemical intervention is distinct from the first in two ways. First, it is intended to abort the trip entirely. Secondly, it is often administered without the tripper's permission and may occasionally necessitate his containment by force. This type of intervention involves the injection of larger doses of tranquillizers intramuscularly on the order of a physician.³ When does the worker decide to take the tripper to a hospital or to seek a doctor to request that

³ When gross body movement is difficult to subdue, the first dose is often given intramuscularly (20 mgs diazepam [Valium]) and repeated after ten or twenty minutes if necessary.

he abort the trip chemically? The following are some guidelines for making this decision.⁴

(1) If the tripper has ingested large quantities of alcohol in addition to the illusionogenic drug, use of tranquillizers may be dangerous. In such cases, the youth worker would *not* recommend chemical abortion of the trip. Injection of tranquillizers may inhibit muscle activity to the extent that the subject's attempts to vomit are unsuccessful and his stomach contents may pass into his lungs or lodge in his throat, blocking respiration.

(2) If he has been able to estimate approximately when the drug was taken, the worker can then make a rough calculation of the time period of maximum dislocation.⁵ If the tripper is exhibiting severe dislocation past the time when the drug effect is at a maximum, the worker may come to the conclusion that it would be best to abort the trip.

(3) In some cases of extreme anxiety and dislocation, the worker may exhaust all of his possible responses without making contact with the tripper. If the tripper becomes fixated on one behavior pattern and the worker is unable to make contact with him in order to interrupt this pattern, it may lead to long-term thought disturbance. In such cases, the worker would also be in favor of aborting the trip.

Prognosis for Effective Intervention and Post-crisis Reflection

In the case of the mild to moderate crisis, the worker has a good chance of successfully helping the tripper to lower his

⁴ These are the worker's guidelines for requesting the doctor's intervention and do not imply that the worker makes the final decision to abort the trip.

⁵ Peak drug effect with most illusionogens occurs from one to five hours after ingestion. Exceptions are DMT which acts more quickly and STP (DOM) which has a more prolonged action than the others. However, these substances are rarely found in street drugs at the present time.

anxiety and accept a degree of dislocation. The experience can often be altered into a mildly pleasant one. The probability of being successful in making this type of intervention is generally evident in the first half hour. At worst, the trip is endured to its eventual conclusion while the worker provides some support. Most aspects of the trip are remembered without difficulty by the subject.

A bonus occurs when after the crisis the tripper honestly reflects on his lack of caution in taking the drug, particularly his failure to recognize instability in his own mental state or in the environment. For example, young people who take strong illusionogenic drugs at rock festivals where there are many uniformed and undercover police may be displaying a need to take risks that is out of proportion to the potential pleasure to be derived. Reflection on the nature of this drive for risk-taking, testing, confrontation, and even failure may be helpful. The accountability of the counter culture to itself is relevant here; the worker who identifies with that culture may be in a position to bring to the tripper's attention some pertinent questions which would usually be rejected if they originated from a "straight" adult.

In instances of severe dislocation and trauma, the prognosis is better than one would anticipate. In the majority of severe episodes, there is little or no recollection of the trip immediately afterward. After a period of sleep the tripper may wake up wondering aloud what has happened to him. With loss of memory the traumatic experience is blocked out and fixated thought patterns are not repeated again.

In the following days and weeks the tripper may come to terms with the episode, providing that he can accept the fact that he was capable of such an experience. Again, as with milder crises, I would hope that the tripper would undertake a rational reassessment of his own behavior and take a more thoughtful attitude to drug use.

Predictors of a Bad Trip

There are, undoubtedly, a multitude of factors that are likely to cause a bad trip. The following seem to be among the most important.

(1) Fatigue. Illusionogenic trips are tiring events and the drug's action often outlasts the tripper's supply of natural energy.

(2) Inexperience. People who have not experienced the sensory effects of illusionogenic drugs are more likely to be alarmed by these effects than users who have tripped many times.

(3) Unreasonable expectations. If the user has unreasonable expectations, particularly if he expects the experience to be "larger than life," he runs the risk of having a bad trip.

(4) Emotional disturbance at the time of ingestion. Illusionogenic drugs often exaggerate an existing emotional state. Therefore, any tendency toward emotional instability would be likely to be amplified. Emotional states prone to amplification would include depressive, suicidal, excited, obsessive, anxious, and confused states. If the tripper has experienced a crisis in the past which still carries considerable emotional impact and/or unresolved conflict, he runs the risk of remembering this experience vividly—of "rerunning a bad movie."

(5) Self deceit. Not all illusionogenic trips result in probing self-analysis. However, this may occur when the tripper does not wish it. If a tripper is unprepared to undergo intensive introspection, he is susceptible to a bad trip.

(6) Unstable immediate environment. Unstable environments include public places with high pedestrian traffic of strangers; unfamiliar environments where people who are unknown to the tripper may enter; locations that might be under police surveillance, such as houses of known drug users; locations where there is a known risk that parents may intrude; and places where a close and mature friend is not available to assist the tripper.

Many young people fail to consider their emotional state or their immediate environment before they take illusionogenic drugs. Ultimately, as I have said, I would probably wish to comment on the lack of responsibility that is involved when a user takes illusionogenic drugs under poor conditions. However, such a discussion serves no useful purpose while the young person is tripping.

Monsieur Seccombe, travailleur spécialisé auprès des jeunes dans le cadre d l'oeuvre Youth and Drug à Toronto, explique les méthodes employées par ses collaborateurs pour aider les jeunes qui souffrent des effets adverses résultant de l'emploi d'une drogue hallucinogène. Il évalue la gravité d'une crise due à la drogue en estimant l'angoisse et l'aliénation de la personnalité chez le jeune homme ou la jeune fille en question. Il intervient alors de façon efficace en rassurant la jeune victime de la drogue, en réduisant son angoisse et en lui donnant un certain sens de sa place dans le cadre physique et social, tout en la persuadant de se détendre et d'accepter l'aliénation temporaire comme étant un élément normal de l'état hallucinogène. Dans certaines circonstances, le travailleur décide de solliciter les services d'un médecin ou d'un psychiatre, et il discute alors certaines règles fondamentales en ce qui concerne cette décision. L'auteur discute également les chances de succès d'une intervention et décrit les facteurs qui risquent de contribuer à un mauvais voyage lorsqu'un jeune prend une drogue hallucinogène.

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Alcohol Use and Alcoholism

By Jan de Lint and Wolfgang Schmidt

In various places and at various times, programs aimed at the reduction or prevention of alcoholism have included total and partial prohibition of the sale of alcoholic beverages, control of number and type of liquor outlets, taxation of beverage alcohol, dissemination of information on alcohol and alcoholism, encouragement of the use of low content alcoholic beverages, and penalties for drunkenness. These programs fall roughly into two groups.

In one group are programs that attempt to reduce the use of all alcoholic beverages whether in the form of beer, wine, or distilled spirits. Proponents of this approach argue that

Mr. De Lint is a Research Scientist at the Addiction Research Foundation and Dr. Schmidt is Associate Research Director there. This article is based on a paper which was presented at the Sixteenth International Institute on Prevention and Treatment of Alcoholism in Lausanne in June, 1970, and which is shortly to appear in the *British Journal of Addiction*. We wish to thank the Editor of the *British Journal of Addiction* for permission to print this adaptation of the paper in *Addictions*.

since rates of alcoholism rise and fall with the overall level of alcohol use in a population, a reduction in the per capita consumption of alcohol must lead to lower rates of alcoholism. In the second group are programs that attempt to encourage "desirable" drinking practices, ignoring the effects of such changes on the overall level of alcohol consumption.

We would argue that while the latter group of programs may lead to a reduction in the proportion of drinking occasions that lead to *drunkenness*, they may also lead to high overall levels of consumption and therefore to higher rates of *alcoholism*. Furthermore, we believe we can demonstrate that preventive approaches that favor reduction of overall consumption would be more effective in controlling prevalence of alcoholism.

Alcoholism Prevalence and Consumption Averages

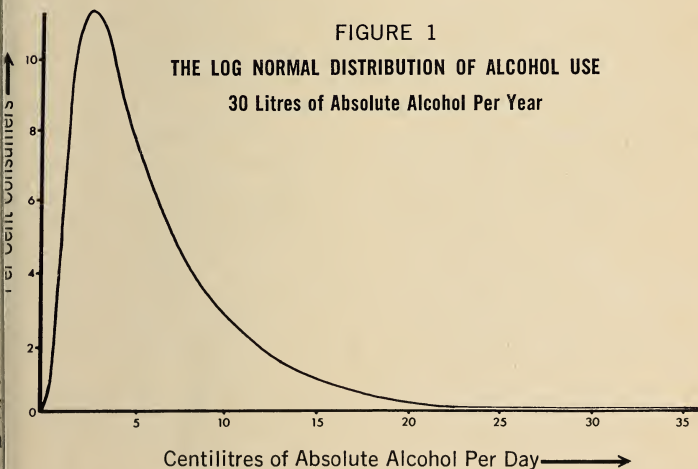
The research that leads us to this conclusion falls within the area of the epidemiology of alcoholism, a field of study in which the aim is to discover the causes of variation in prevalence of alcoholism both through time and from one region to another at the same point in time.

Prevalence of alcoholism can be measured directly or indirectly. However, it is difficult and cumbersome to make direct estimates by head counts, and indirect methods are more commonly used. Indirect methods rest on the assumption that the behavior of a population of alcoholics will be reflected in certain statistics that are regularly reported by governments. These include hospital admissions, convictions for drunkenness, beverage alcohol sales data, and statistics on causes of death that are attributable wholly or in part to consumption of alcohol.

Among the indirect methods of prevalence estimation, the most widely used is the Jellinek Estimation Formula, which uses statistics on death from cirrhosis of the liver. Largely through application of this method, it has been established

that there is a close relationship between per capita consumption of alcohol and alcoholism prevalence.

Further evidence for the close relationship between per capita consumption and alcoholism prevalence comes from studies of the distribution of alcohol consumption. Individual consumption in a given population ranges from very small quantities to near lethal amounts of alcohol. It has been demonstrated for a variety of populations that the distribution of these levels of consumption closely approximates a smooth, skewed curve of the type known to mathematicians as the logarithmic normal curve. For example, in a population with an average consumption of 30 litres of absolute alcohol per year,¹ the distribution of consumption is as shown in Figure 1.



¹A pint of Canadian beer (5% alcohol by volume), or a 1½-ounce shot of Canadian distilled spirits (40% alcohol by volume), contains about 1.7 centilitres of absolute alcohol.

The consumption of alcohol by alcoholics is represented in the tail of the curve—in the upper ranges of consumption. However, the transition from moderate to excessive quantities is very gradual; therefore definitions of the consumption levels of alcoholics must be arbitrary. For example, should consumption be defined as alcoholic when in excess of 15 centilitres or when in excess of 20 centilitres of absolute alcohol daily?² No matter what cut-off point is used to define alcoholism, its prevalence is invariably determined by the overall level of consumption in the population.

In Table 1, the rates of drinkers who consume more than a daily average of 15 centilitres of absolute alcohol are shown for a number of countries.

Accessibility

It is apparent that these countries vary greatly in alcoholism prevalence. These differences have been explained in a number of ways. For example, in countries which have high rates of alcoholism prevalence—high overall levels of alcohol consumption—such as France, Italy, and Portugal, alcoholic beverages are readily available and quite inexpensive. Indeed, it would be difficult to imagine alcoholic beverages as an incidental part of everyday living if they were expensive and hard to get. Conversely, low accessibility usually results in a low level of consumption. For example, during Prohibition in the United States both overall level of alcohol use (that is, use of beverages that were illicitly procured and distributed) and rates of liver cirrhosis mortality were greatly reduced.

The effect of less drastic government measures regulating conditions such as the number and type of liquor outlets and

²We would prefer to define alcoholic drinking as consumption in excess of a daily average of about 15 centilitres of absolute alcohol because this approximates very closely the range of consumption typically reported by patients in alcoholism clinics in Canada and in several other countries.

TABLE I
ESTIMATED RATES OF DRINKERS IN EXCESS OF A DAILY AVERAGE OF
15 CL. OF ABSOLUTE ALCOHOL

COUNTRY	Estimated Rates of Drinkers in Excess of a Daily Average of 15 Cl. of Absolute Alcohol per 100,000 Population Aged 15 and Older.
France	9,405
Italy	5,877
Portugal	5,652
Spain	4,635
Austria	4,212
W. Germany & W. Berlin	3,978
Switzerland	3,901
Luxembourg	2,988
Hungary	2,952
C.S.S.R.	2,655
Canada	2,272
U.S.A.	2,198
Belgium	2,052
England & Wales	1,946
Rep. of Ireland	1,946
Denmark	1,848
Poland	1,752
Sweden	1,515
Netherlands	1,456
Finland	945
Norway	945

hours of sale is more difficult to evaluate. At the present time, it appears that these factors alone do not greatly affect variations in consumption except where there has been outright

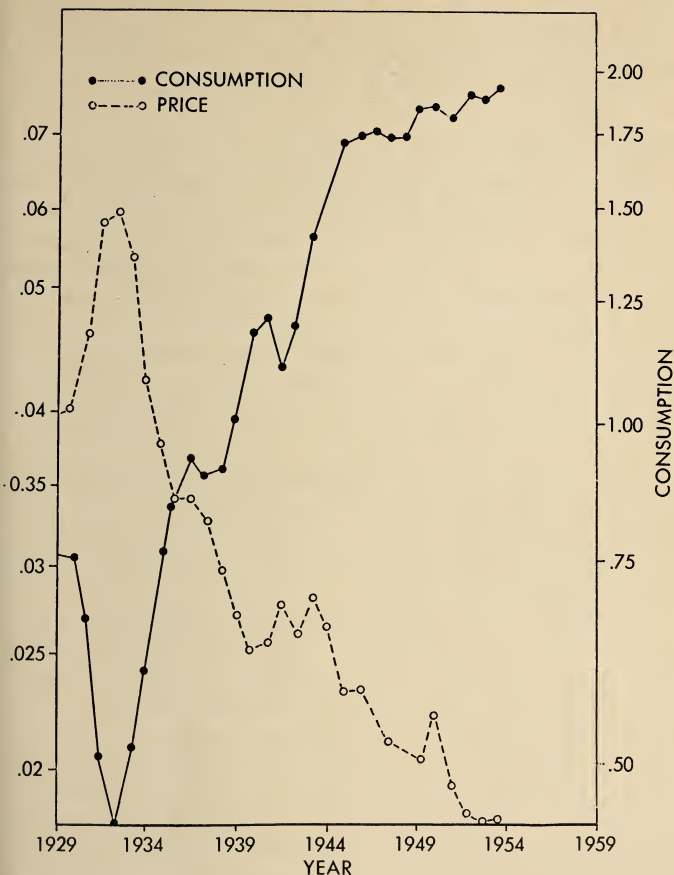
prohibition or great scarcity of liquor outlets. Finland provides us with an example of how an increase in the number of liquor outlets measurably affected overall consumption. In rural Finland, where liquor outlets are quite rare, the government introduced stores for beer and wine in some selected communities on a trial basis (1957). This led to a marked increase in the consumption of all legally sold beverages, particularly beer and wine. More recently, the government allowed beer to be sold in a wide variety of stores and eating places. Within a year after the introduction of this measure, alcohol consumption increased approximately 50%. Unfortunately, there are no recent data available that would show the effect of *decreased* accessibility (short of total prohibition) on alcohol consumption.

Cost

Access to alcoholic beverages is also affected by their cost. Since they can be produced and distributed quite inexpensively, variation in price among countries and from period to period is largely owing to differences in taxation policies. The important variable is not absolute cost, but cost relative to disposable income—in other words, the individual's ability to buy. It has been observed that as the price of alcohol relative to average disposable income goes up, consumption goes down. In Figure 2 the remarkably close association between relative cost and consumption is shown for Ontario.

The role of relative price has been examined for many other countries and regions. In all cases relative price has been found to be related to overall consumption and to prevalence of alcoholism. Unfortunately, these investigations have usually covered periods during which price relative to income has decreased. It would be useful to know whether such a relationship would also hold in a reverse situation—i.e., whether consumption would go down were prices relative to disposable income to rise gradually.

FIGURE 2
ALCOHOL PRICE AND CONSUMPTION IN ONTARIO



Price = the price of an average gallon of absolute alcohol
expressed as a fraction of an average disposable income

Consumption = the consumption in gallons of absolute alcohol per
person 20 years and older

In this context, it should be noted that the amount of alcohol taxation, and thus the cost of beverage alcohol, often reflects the degree of acceptance of alcohol use in society. Consequently, we will now turn to a discussion of some of the social and cultural aspects of alcohol consumption behavior.

Drinking Practices

One of the important questions in the alcoholism field concerns the relationship between customary drinking practices and alcoholism prevalence. For example, the low prevalence of alcoholism among Jews in North America has been attributed to their strong disapproval of drunkenness and their use of alcoholic beverages in religious observances. In contrast, the drinking practices of the Irish have been characterized as predominantly "utilitarian" (the use of liquor to alleviate physical and emotional discomfort is an example of this), and the allegedly high rates of alcoholism among the Irish have been attributed to this attitude. The Italian custom of drinking with meals is said to be conducive to a low prevalence of alcoholism, whereas the high rate of alcoholism in France has been attributed to the custom of drinking on many occasions throughout the day.

Although it may appear from such studies that certain drinking customs are typically associated with high or low rates of alcoholism, such a conclusion is not quite justified. First, the assumed rates of alcoholism for these cultural groups are not always supported by estimates based on overall consumption data and liver cirrhosis mortality data. In the case of Italy, both these measures indicate a very extensive alcoholism problem. (Rate of excessive consumption per 100,000 adults is 5,877 and the rate of death from liver cirrhosis per 100,000 adults is 27.3.) Conversely, these same measures show that the Irish in Ireland have relatively low rates of alcoholism. (The rate of excessive consumption per 100,000 adults is 1,946; death rate from liver cirrhosis per 100,000 adults is 4.5.)

Secondly, in investigating the relationship between drinking practices and rates of alcoholism, the total volume of consumption must be taken into account. It was shown earlier that alcoholism prevalence in a population is intimately related to the overall level of alcohol consumption. It follows, therefore, that any factor that affects the volume of consumption inevitably affects the alcoholism prevalence rate and vice versa. Clearly the French habit of using alcoholic beverages on many occasions implies a high level of overall consumption. Accordingly, this drinking practice is accompanied by high rates of alcoholism.

On the other hand, drinking practices which typically involve seeking intoxication do not necessarily imply a high volume of consumption if drinking occasions are fairly infrequent. Thus, in Finland, drunkenness is very prevalent but annual consumption and rates of alcoholism are relatively low.

Specific Beverage Consumption

It has frequently been argued that consumption of distilled spirits is more likely to lead to alcoholism than consumption of the lighter beverages. For this reason sale of distilled spirits is often subjected to more legal restrictions and higher taxation than sale of other types of beverage alcohol.

The alleged importance of distilled spirits in the development of alcoholism would seem to draw support from the observation that consumption of these beverages leads more rapidly to intoxication than consumption of identical amounts of alcohol in the form of wine and beer. However, only a little more time and effort is required to achieve intoxication with beer and wine. Furthermore, there is no evidence that the speed at which intoxication is achieved is relevant in the development of alcoholism.

It is of interest that the beverage preference of alcoholics does not depart much from that of the drinking population at large. For example, in Australia and in South Germany, beer

is the most commonly used beverage, and according to clinical reports also the beverage of choice of most alcoholics.

Perhaps the best argument against the notion that use of distilled spirits is more likely than use of other alcoholic

TABLE II
RATES OF EXCESSIVE USE AND CONTRIBUTION OF DISTILLED SPIRITS TO
TOTAL CONSUMPTION FOR VARIOUS COUNTRIES 1966-1967

COUNTRY	Estimated Rates of Drinkers in Excess of a Daily Average of 15 Cl. of Absolute Alcohol per 100,000 Population Aged 15 and Older.	Per Cent Contribution of Distilled Spirits Consump- tion to Total Alcohol Consumption
France	9,405	13.5
Italy	5,877	12.6
Portugal	5,652	4.1
Spain	4,635	20.7
Austria	4,212	18.2
W. Germany & W. Berlin	3,978	21.2
Switzerland	3,901	17.7
Luxembourg	2,988	13.0
Hungary	2,952	21.8
C.S.S.R.	2,655	17.4
Canada	2,272	36.0
U.S.A.	2,198	46.0
Belgium	2,052	15.0
England & Wales	1,946	14.2
Rep. of Ireland	1,946	34.4
Denmark	1,848	17.2
Poland	1,752	61.2
Sweden	1,515	54.0
Netherlands	1,456	37.0
Finland	945	46.7
Norway	945	45.8

beverages to lead to alcoholism comes from a comparison of countries according to rates of excessive use and the contribution of distilled spirits to the total consumption.

Many countries in which a large proportion of alcohol is consumed in the form of beer and wine, rather than in the form of distilled spirits, have high rates of alcoholism. Indeed, in some of the countries in which the contribution of distilled spirits to total alcohol consumption is large (e.g., Finland) the predominant drinking pattern consists of occasional consumption of intoxicating amounts. It is likely that the prevalence of intoxication may be somewhat reduced by a program of promoting the use of beer and wine. However, it does not follow that the rate of alcoholism will be reduced by such a program.

Psychological Factors

Some attempts also have been made to explain variations in prevalence of alcoholism on the basis of differences among populations in the prevalence of emotional disturbance. It is argued that in socio-cultural environments which produce a great deal of inner stress and tolerate "utilitarian drinking" (e.g., drinking to unwind) as a way of adjusting to such stress, high rates of alcoholism will occur.

This theory raises a number of questions. It is difficult to develop useful ways of measuring and comparing the mental health of various populations. For example, how would one compare the mental health of the Swedish nation to that of the French? At best, such a comparison would involve highly arbitrary definitions and procedures. Furthermore, if high rates of alcoholism were in part attributable to a high rate of emotional disturbance and to utilitarian drinking, we would have to conclude that in countries such as France, Portugal, and Italy these factors must be very common. However, there is no evidence to support this notion.

Another theory is the "vulnerability-acceptance hypothesis" in which emotional disturbances are linked with the acceptance of alcohol use. In societies with a low acceptance of drinking, according to this view, only those people who are highly vulnerable psychologically will go against the social norms and become exposed to risk of alcoholism. Therefore, the proportion of severely disturbed people in the alcoholic population in such societies will be high. But in societies with a high degree of acceptance of regular, heavy alcohol use, many individuals with low vulnerability, both physical and psychological, will also be exposed to the risk of becoming alcoholic. The proportion of severely disturbed people in the alcoholic population will then be lower.

This hypothesis seems to hold true when one compares countries which vary greatly in levels of overall consumption. Where the overall level of consumption is low, drinkers of alcoholic quantities comprise a relatively small segment of the population and their drinking deviates drastically from the drinking norm. It would not be surprising if such drinkers typically were persons who also deviated in other respects. Conversely, in high consumption countries the drinking of alcoholic amounts is much more common, and therefore, one would expect the rate of emotional disturbance among alcoholics to be lower.

Prevention of Alcoholism

Current epidemiological findings lend strong support to preventive programs which aim at reduction of overall consumption of alcohol. Since rates of alcoholism rise and fall with the overall level of alcohol use in a population, a reduction in the per capita alcohol consumption must lead to lower rates of alcoholism. For this reason, it would seem that the taxation of beverage alcohol and other control measures that reduce accessibility would be effective, particularly if there were also a wide acceptance of the public health value of such controls.

The merits of programs that aim at the bringing about of "desirable" drinking patterns are, as we have said, questionable. To promote drinking with meals or at other daily occasions may conceivably lead to a reduction in the rate of intoxication relative to all drinking occasions. However, evidence to date would indicate that such drinking patterns also lead to high overall levels of consumption and to higher rates of alcoholism.

Unanswered Questions

Evidently many questions remain to be explored. Why does the distribution of drinkers according to their consumption approximate a logarithmic normal curve? Is the quasi-mathematical connection between alcoholism prevalence and per capita consumption unalterable? What specifically determines a person's level of consumption at any point in time? What leads him to decrease or increase his consumption? Why is it that only a relatively small proportion of drinkers progress to extremely high levels of consumption?

We would like here to quote the late Sully Ledermann, whose work on alcohol consumption and alcoholism has greatly influenced current epidemiological thinking. "This quasi-mathematical connection between reasonable consumption and unreasonable consumption which the available data show, without any exception cited, seems to be the most important result; for it has the most direct effect on anti-alcoholic action, in leaving among other things, little hope for those who hope to reduce alcoholism without affecting the consumption and production."

It should be understood that we do not propose some new sort of "temperance" movement (using "temperance" here as the word is often used—to mean abstinence). Rather, we suggest that the magnitude of the alcoholism problem can be reduced through reducing the *general* level of alcohol consumption. This is in keeping with a recent—and current—shift

of emphasis, within the Addiction Research Foundation, away from concentration on clinical approaches and toward preventive approaches to the problem.

As long as we looked upon "alcoholics" and "social drinkers" as two entirely separate groups, it was reasonable for us to ignore drinking in general and to concentrate on rehabilitation of alcoholics. But now our studies have shown that these groups are *not* separate populations, and that as per capita consumption of alcohol increases there is a proportionately higher number of alcoholics. Therefore, we have been forced to realize that there is no great hope of reducing the numbers of alcoholics or of those who drink at levels hazardous to their health without rolling back the overall consumption of alcohol throughout our society.

It is because of this—*not* because of some impossible (and probably undesirable) notion of reducing consumption to zero—that it may be necessary to oppose some of the further liberalizations now being proposed for our liquor legislation in this Province.

Certains programmes concernant le domaine de la prévention contre l'alcoolisme tentent à remplacer les exemples connus de libation "excessives" (à savoir, consommation de boissons pour remédier à un malaise quelconque, psychologique ou physique) par des habitudes plus "satisfaisantes" (à savoir, boissons prises pendant les repas ou autres réunions sociales), sans se préoccuper des effets causés par les ordonnances en vigueur, sur le niveau généralement constaté de la consommation d'alcool. D'autres programmes de prévention visent principalement à réduire la consommation générale en vue de diminuer le taux actuel d'alcoolisme de la population. Cette seconde méthode est débattue par les auteurs de cet article qui, ce faisant, discutent de la relation possible entre les facilités d'accès, le coût d

l'alcool, les pratiques usuelles des buveurs, les facteurs psychologiques et la consommation spécifique de boissons (bière, vin, spiritueux), et l'alcoolisme existant. Leurs conclusions confirment que la réduction des facilités d'accès aux boissons alcoolisées pourrait également réduire le taux actuel d'alcooliques, à condition, cependant, qu'en même temps, la valeur de tels contrôles pour le bénéfice de la santé publique soit largement reconnue.

Reprints of Addictions Articles Available

Reprints are available of many of the articles that appear in *Addictions*. If you are a resident of Ontario and would like to receive, free of charge, one or more copies (any reasonable quantity) of any of the reprints listed below, please contact your nearest ARF office. The telephone number will be found on the inside front cover of *Addictions*.

Alcoholism: A Merry-Go-Round Named Denial by Joseph L. Kellermann.

The Extent of Drug Use in Metropolitan Toronto Schools: A Study Changes from 1968 to 1970 by Reginald G. Smart, Dianne Fejer, and Jim White.

Illusionogenic Crisis and Effective Intervention by Wally Seccombe.

Marihuana and Its Effects: An Assessment of Current Knowledge from the office of the Executive Director, ARF.

Marihuana, the Experts, and the Public by Oriana Kalant.

Preliminary Brief to the Commission of Inquiry into the Non-Medical Use of Drugs from the Research Division of the ARF.

The Role of the Union in Industrial Alcoholism Programs by James A. Belasco, Harrison M. Trice, and George Ritzer.

Summary With Comments on the Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs.

Traffic Accidents of Alcoholics by Reginald G. Smart and Wolfgang Schmidt.

Also available is *Legal Considerations in Counselling Young People* by Robert F. Reid, which appears in this issue.

Legal Considerations In Counselling Young People

By Robert F. Reid, Q.C.

Questions are repeatedly asked by both professional staff and volunteers about the possible legal consequences of counselling young people. An attempt is made here to deal briefly with the questions that most frequently arise. Workers ask themselves:

(a) Do I have a legal obligation to inform parents that I am counselling their child?

(b) Do I need the parents' consent to do this legally?

(c) Is there any significant difference between "counselling" and "treating"?

(d) Must I inform the police or other authorities that I know or suspect that a young person is committing an offence, such as being in possession of marihuana?

(e) What is the offence of "harbouring"?

(f) What constitutes the offence of "contributing to juvenile delinquency"?

Mr. Reid is legal counsel to the Addiction Research Foundation. He wishes to acknowledge the assistance of Stephen Grant in the preparation of this paper.

The material in this article was developed primarily for the information and guidance of those Foundation staff members who offer counselling to young people. It is presented here in the belief that it will be of value to many other counsellors as well as to many teachers and volunteer workers. Parents—and young people themselves—may also find that Mr. Reid has clarified for them, in a straightforward and useful manner, a number of topics that are of interest.

Answers to these and similar questions do not appear to be easily available to people working in the field. This is an attempt to provide some guidance.

An understanding of the law governing young people is a help to understanding the law governing their counsellors. Some understanding of both is essential to proper counselling. Experience shows that the lack of it may lead the counsellor to be either too timid or too bold. It must be stressed, however, that no general statement of law can be completely exact. There are exceptions to almost everything. Small differences between the facts of one particular case and the facts of another case can make large differences in law. What is set out here are general principles and considerations.

The General Law

The age of 21 is a critical one in law. It forms a line separating two distinct legal categories. The law that governs those above the line is in some ways different from that which applies to those below it. The most important general difference is that, by and large, a person over 21 can acquire rights and be subject to legal obligations on his own by contract whereas a person under 21 cannot.

Twenty-one is not the only significant age for young people, or for those dealing with them. Many offences have been created which relate to age categories lower than twenty-one. All of these appear to have been devised for the protection of young people. It is thus an offence to "harbour" a child under 14 or to endanger the morals of a child under 18. It is an offence to sell alcohol to persons under 21 or firearms to persons under 16.

Similarly, some actions are offences when committed by persons in certain age categories under the 21 line. The offence of "juvenile delinquency" is an example. It relates to different ages in different provinces. In Ontario, it applies to certain actions committed by anyone who is under 16. This

offence has an important significance for anyone over 16 in Ontario as well, for the related offence of "contributing to juvenile delinquency" applies to anyone without regard to age and may result in serious penalties.

In law, a person under 21 is a "minor" or an "infant." These terms are used synonymously. No matter how quaint it may be to refer to today's teenager as an "infant," the term does have an exact legal meaning. In contrast the word "child" has no single legal meaning. Its meaning may vary widely in accordance with the context in which it is used. A child for the purposes of the offence of "harbouring" is defined by the statute as a person under 14, whereas a child in relation to the offence of endangering the morals of children is a person under 18. The word "juvenile" can also vary in its meaning; it may mean persons under 16, 17 or even 18, depending on the province involved.

For the purposes of our civil (i.e. other than criminal) law the most important age limit is 21, for it affects a person's capacity to make a valid contract. For the purposes of the criminal law the most important age in Ontario is 16, for those under it are "juveniles" and subject to The Juvenile Delinquents Act. (It may be of interest that there appears to be no lower limit for criminal capacity. Under the Canadian Criminal Code the minimum age for criminal capacity is clearly set at 7 years, but there is no such limit under The Juvenile Delinquents Act.)

Minors' Contracts

Contrary to the view held by many young people, contracts made by a person under 21 are not automatically invalid. It is true that they are as a general rule, but contracts for "necessaries" might, nevertheless, be enforced against a minor. The trouble is that the question of deciding what are necessaries may be what lawyers call a "nice" one, which means it might be difficult and therefore susceptible to appeals

and protracted legal proceedings. Anyone who sells goods to a minor consequently runs the risk of not being able to obtain payment. This is so notwithstanding that the contract might have been in writing and signed by the minor. Even if contracts are in writing and signed and for "necessaries," the expense and trouble involved in legal proceedings deters many from taking court action on them. Attempts to enforce contracts against minors by suits in civil courts are rare. It is this reluctance to bring suit, rather than the inherent invalidity of such contracts, that appears to lead minors to imagine themselves always to be immune from suit.

There is an additional technical difficulty. A minor cannot by himself sue or be sued in the civil courts. If he chooses to sue, he must do so through an adult known as his "next friend." This will be normally his parent or guardian. He may be sued only if the court appoints a person known as a "guardian *ad litem*" (that is, a guardian for the purposes of litigation) to represent him in court.

Minors' Consents and Releases

Foundation personnel are not usually concerned with minors' contracts. They are, however, frequently troubled by the thought that they should obtain a written consent or a release before dealing with a young person. "Consents" and "releases" are different in form but for the purpose of this discussion are treated as being the same in effect. The term "consent" is sometimes used here alone for convenience.

What has been said about minors' contracts might lead one to think that a minor is not capable of giving a valid consent. Logic would suggest that if a minor cannot as a general rule bind himself to a legal obligation, as in a contract, he can equally not deprive himself of his rights, as in a consent or release. Logic and law, however, do not always go hand in hand and we have here a situation in which the law refuses

to be parcelled up so neatly. The fact is that the law relating to minors' consents and releases is none too clear.

The courts in considering the validity of minors' consents have not always accepted the analogy to contract law. They have tended to ignore the magic with which the law of contract has invested the age of 21. They tend rather to ask whether the minor was, in the circumstances, capable of appreciating fully the nature and consequences of his act of giving consent. The answer to this question will turn particularly on the degree of intelligence and maturity shown by the minor. If a court concludes that a person was capable of appreciating the nature of his act, it may treat a consent as effective notwithstanding that the person giving it was under 21. (This occurred in a recent case in the Supreme Court of Ontario where the consent of a 20 year old to a surgical procedure was held to be valid. This holding is consistent with s.42 of Regulation 523 under the Public Hospitals Act (Ont.) which implies that the consent of a person over 18 is valid, although the section was not discussed in the judgment.)

The result is that, although minors' consents may on occasion be treated as valid their validity is always open to challenge. As a practical matter they must be treated as of doubtful value.

Parental Consent

It is frequently suggested that this doubt may be removed by means of a consent obtained from the parent. This is questionable. We again appear to be in an area where the law is uncertain. It is a principle of the law that one person may not make a contract that binds another without his consent; that is: no one is invested with inherent authority to bind another. Parents are in no different position than other people in this respect. It would therefore be strange if a parent could release claims that his child would otherwise have. The problems that could arise—oddly enough, few have—can be easily imagined.

What if the parent gives consent and the minor refuses? If the minor's refusal is later held to be valid, is the parent's consent invalidated? What of the reverse situation?

Again, prudence demands that parental consent be treated as of doubtful effect.

The lesson to be learned from all this is that a consent or a release from a minor may be slight protection against legal proceedings. It will not likely deprive a minor from asserting claims that he would otherwise have. Care must therefore be taken to deal with persons under 21 in such a way that no law is breached and no right violated.

It might not be amiss to add a word on consents and releases generally because of widespread misconceptions about their effectiveness. They are not the defensive shield that they are popularly thought to be, even when obtained from adults. A "release" of claims is intended to be a defence against future claims. It might prove to be a fragile one. Courts tend to look at all the circumstances surrounding the giving of a release. They are quick to set them aside where they appear to have been obtained by trickery or under duress, or where the person giving one was not aware of all the relevant facts. The fragility of their nature as a defence is merely increased when they are obtained from minors.

Is Consent Needed for Counselling?

What is said above deals with the validity of consents obtained from minors or their parents. The question for most Foundation personnel is, however, whether a consent is needed at all. The commonest transaction involving Foundation personnel and young people is counselling. Counselling is a word of vague import and is used by some as synonymous with "treatment," but "counselling" as used here is not treatment, in the sense of medical treatment. This distinction must be kept in mind by Foundation personnel, for no one but a medical doctor or other person properly authorized by a legis-

lature may give medical treatment. There are severe penalties for the unauthorized practice of medicine.

The law and practice that relates to consents to treatment does not apply as such to counselling. For instance, section 42 of Regulation 523 of The Public Hospitals Act, which requires a written consent to be obtained before the performance of a surgical operation, is not applicable. In fact, there is no positive obligation imposed by law to obtain a consent to counselling. A person under 21 may be counselled without any written consent having been given by either that person or his parent or guardian. It goes without saying that no one may counsel the commission of an unlawful act.

If the law imposes no requirement, is there any need for one? It must be remembered that consents are obtained not only because the law requires it but through simple prudence. A consent to treatment other than surgery would be obtained because of the dictates of prudence, not law.

The absence of a positive law requiring it does not mean that a consent should never be obtained from minors. Consents may have some value in deterring baseless claims although they are not likely to have a deterrent effect on good claims. More importantly, a written consent is of value in preventing a later dispute over what was agreed to. This is something of prime importance. Special considerations do, however, apply to obtaining releases or consents from minors. Care must be taken to avoid any future suggestion that the release or the request for it was unfair or that any advantage was being sought over the young person.

The Juvenile Courts

The general effect of The Juvenile Courts Act is to separate juveniles from adults in relation to the enforcement of the criminal law. Exceptions may be made to this general rule, but they are small by comparison to the number of criminal cases dealt with in the Juvenile Courts. In the result, the

juvenile who does something that would be an offence if done by an adult—say, for instance, steals something—must be brought before the Juvenile Court, not the ordinary criminal court. He can, and probably will, be charged there, with “delinquency” and dealt with by that court instead of being charged with “theft” and dealt with in the ordinary criminal courts. (This is not inevitably the case. As will be seen later, his case may be “waived” to the ordinary criminal courts.) If his case is retained by the Juvenile Court, and if he is detained to await trial and not granted bail, he will normally be kept in a detention home or “shelter” with other juveniles, not with adults in the county jail (in Toronto, the “Don”).

The disposition of his case in the Juvenile Court is intended to be, in the words of the Act, “as informal as circumstances permit.” This is in contrast to proceedings in the ordinary criminal courts where extreme formality is, quite properly, the rule. The object of the Act when it was passed was to provide guidance and supervision for the erring juvenile, who is to be treated “not as a criminal, but as a misdirected and misguided child . . . needing aid, encouragement, help and assistance.” Consistently with this objective, proceedings in the Juvenile Court are private and may not normally be published in a newspaper or elsewhere.

Alternatives for the Judge

The judge is given a wide choice of ways to dispose of a case, in contrast to the ordinary criminal courts, where the judge will normally have the power on conviction only to impose a fine or a term in jail or to suspend sentence or grant probation. The Juvenile Court judge may simply make no immediate disposition of the case at all. He may adjourn it indefinitely. Alternatively, he may impose a small fine, or allow the child to remain in his own home on probation; or cause him to be placed in a foster home; or impose other

conditions that seem appropriate; or commit him to a children's aid society or an industrial school. Even if one of these courses is taken, the disposition is not necessarily final, for the conditions imposed may be varied until the child reaches 21.

The jurisdiction of the Juvenile Courts is not restricted completely to persons under 16. A child charged with juvenile delinquency may become subject to the supervision of the Juvenile Court until he reaches 21. Furthermore, even if he has passed the age limitation of 16 prevailing in Ontario (or 17 or 18 prevailing in other provinces) he may still be charged and dealt with in the Juvenile Court for an offence committed while under the age of 16.

An exception to this procedure may be made where the child is over the age of 14 years and the offence is a serious one (i.e. an "indictable" offence). The judge of the Juvenile Court has a discretion to "waive" the matter to the ordinary criminal court. If that is done, the case will be proceeded with in the same way as if the child were an adult. Which course is followed is primarily for the judge of the Juvenile Court to decide. (His decision is subject to appeal.) He is adjured by the legislation to send the child before the ordinary criminal courts only where he is of the opinion that "the good of the child and the interest of the community demand it." There is, as a result, some variation in the treatment of young offenders suspected of serious offences. Offences involving serious theft or even murder may be tried in the Juvenile Court as "delinquency" or in the ordinary adult courts as the actual offence. A recent example of the latter procedure was the Truscott case in which a child of 14 was not tried in the Juvenile Court, but in the ordinary criminal court.

Relevance for Counsellors

Possible offences under the Act are not confined to minors. Adults may be charged with the offence of "contributing" to

juvenile delinquency, or of "inducing" a child to leave a home in which he has been placed by the Juvenile Court. Parents or guardians may be charged with neglecting to take steps to prevent a child from becoming a delinquent and may also be ordered to pay any fine, damages, or costs incurred by a child. Of these possible offences, the most relevant to counsellors are those of "contributing" and "inducing." These are dealt with later at greater length.

This describes briefly the present situation. Not everyone is happy with it, and counsellors to the young may be interested in the controversy surrounding the proposed "Young Offenders Act" (Bill C-192) now before Parliament at Ottawa. The present Act rests on the assumptions that the judge of juveniles should be more counsellor than judge and that informality in proceedings is in the interest of children. These assumptions are now being challenged. Among the other possible consequences of the passage of the proposed Young Offenders Act would be: the repeal of The Juvenile Courts Act, the disappearance of the offence of juvenile delinquency and hence of "contributing," the increasing of the jurisdiction of the court through the raising of the upper age limit in Ontario of persons subject to it from 16 to 17, and the introduction of the concept that a person between the ages of 10 and 20 years can properly be found to be a "youthful offender." Notwithstanding the obvious sincerity of the proposed Act's proponents, opposition to it has been strong: the Canadian Mental Health Association has described it as "a Criminal Code for children which is distasteful in its terminology, legalistic in its approach and punitive in its effect."

So much for background. We now turn to typical questions that have been raised over the years.

Question 1. May I legally counsel a minor without his parents' knowledge or consent?

A. Yes, you may. There is no difference in law between counselling an adult and counselling a minor. You may not,

however, counsel the commission of an offence, for that is in itself an offence. This rule applies to all age groups. You do not need the parents' consent in order to counsel a minor. Nor are you under any legal obligation to inform the parents. However, there may be situations in which it would be prudent, and in the minor's interest, to inform parents. This, however, is a question of policy and not law. As will be seen, the "policy" question may be just as important as the "legal" one. That is why a discussion of the importance of "policy" occurs later in this article.

Question 2. May I "treat" a minor?

A. This question is repeatedly asked. On inquiry, it usually turns out that "treat" in this context is used to mean counsel or advise, and is not used in the medical sense of dispensing drugs or medicine. It is fundamental that only medical doctors or persons under their direction may dispense or prescribe medicines or drugs. Anyone else who does so is open to a charge of illegally practising medicine. If "treat" is used in the sense of "counsel" or "advise," however, the answer given to Question 1 equally applies to this question.

Question 3. May I keep a minor in a hostel or hospital or any other place against the wishes of his parents?

A. The answer to this in the case of a child under 14, is a clear *no*. You may not interfere with a parent's right to possession of his child. If you do so, you may be charged with "harbouring." Section 236 of the Canadian Criminal Code is to the effect that a person who intentionally deprives a parent or guardian of possession of a child under 14 is guilty of the offence of harbouring, which carries a possible penalty of 10 years' imprisonment.

The answer is also "no" in relation to a minor who has been placed in a home, foster home, school, or institution by the Juvenile Court. Section 34 of The Juvenile Courts Act

makes it a serious offence to induce or attempt to induce a minor to leave such a place, or knowingly harbour or conceal one who has left without notice to the Juvenile Court, home, institution, or police.

An offence related to harbouring is that of "abducting" a female under 16. The essence of this offence is the deprivation of a parent or guardian of the care of the child against his will. The penalty here may be five years. The girl's consent to being kept from the parent or guardian without his consent is immaterial; it is an offence even with her consent or even at her suggestion. Similarly, it is immaterial whether or not the accused believes that the female person is 16 or over. If she is in fact under 16, it is no defence that the accused thought she was older.

Question 4. Must I tell the parents that a minor is staying in our hostel or hospital?

A. In strict law the answer is no, but certain considerations should be given some weight. The offence of harbouring requires some positive act intended to deprive the parent of possession of the child. Thus, if a child under 14 comes of his own volition, there does not appear to be any positive legal obligation to notify a parent and if he wants to stay, even if he is under 14, there is no strictly legal obligation on you to notify anyone. If, however, the parents find out that he is there and want him back, you must comply with their wishes unless there is some other legal and proper alternative open to you. There may be, for instance, circumstances in which it may be obviously harmful or dangerous simply to hand over a child to a parent or guardian. This could arise where the parent or guardian is drunk or threatening. In such a case it is open to you to call the Children's Aid Society, who may take a child under 16 into their care to save him from harm. For older children, the safest course would be to call the police.

All these comments are made on the assumption that the person involved wishes to stay. You cannot detain a person

against his will. That would expose you to a host of offences, among them kidnapping and false imprisonment, all of which apply whether the person is over or under 21.

Also, the fact that a person has a desire to stay may not always entitle you to permit him to stay. As was observed in the answer to Question 3, a minor (who may for this purpose be a person under 21) under the supervision of the Juvenile Court is in a special category. There appears to be a positive obligation to give notice to the authority in whose charge he should be, if you discover that he is under the supervision of the court.

Question 5. If a minor consults me and tells me that he is involved in pot parties, or engaging in some other illegal activity, am I under any legal obligation to report this to the authorities?

A. This is a question that bothers many people, particularly teachers. Students confide in them and in the course of attempting to help them or, for that matter, just listening, they become aware that the students are "doing dope" or have it in their possession, or are passing it on. Also students frequently tell teachers of parties or incidents that are about to happen, not just those that have happened.

The general answer is that the law does not require you to be an informer. A policeman is entitled to arrest a person whom he has reasonable grounds to believe is committing an offence, and so are you. The policeman's duty is to make an arrest, but you are not under any legal obligation to do the same. Nor are you required or obliged by law to report to the police or other authorities your suspicions or even any facts you have concerning an offence.

The question whether you *should* report and to whom may, however, be a difficult one nonetheless. Most people have encountered situations in which reporting suspicious facts to the police was desirable and proper in order to secure their own protection or the safety of others. These considerations

do not vanish simply because you are dealing with someone else's life and problems and not just your own.

It is true that simply sitting back and doing nothing will probably not amount to aiding, abetting, or counselling an offence, and the law does allow you to sit back and do nothing. However, it will nearly always be appropriate to attempt to persuade a person involved in breaking the law to desist, if only for his own good. There are many reasons why the fact that the law allows you to do nothing might not always amount to a moral justification of inaction on your part.

If, for instance, you are dealing with a person who is homicidal or suicidal and who is consuming drugs or alcohol before your very eyes, he might kill himself or you or someone else, or at least cause serious harm. It would be unfair, and unwise and morally unjustified simply to stand by and watch the harm develop. Telling his family, or the police, might be the right thing to do. Similarly, in the case of a person who is incapable of looking after himself because of drugs, his only salvation may be his parents or a hospital or even the police. The decision that you make may not, in the result, have very much to do with your legal obligation.

Reporting on a person whom you are counselling might well, however, destroy the relationship of trust between you, and you would do it only in circumstances that demand it. If you do decide that it is in your patient's best interest to report him, you should consult him first. Otherwise he may very well think that he has been betrayed. Perhaps you should, initially anyway, try to talk him into reporting himself to whoever might be able to help him.

The point that is being made here is that the law, by itself, might not provide a criterion for your course of action. The question, "Should I tell someone that X is seriously, or even desperately, into drugs?" is not really a question of law at all. The law requires nothing from you. It places the burden of decision right back on your shoulders and leaves it to be

decided, by you, on the basis of moral and humane considerations.

Question 6. What is “contributing to juvenile delinquency”?

A. A juvenile delinquent is defined, for Ontario, as a person under 16 who does any act that in an adult would be an offence under federal, provincial, or municipal law, or who is guilty of “sexual immorality or any similar form of vice.” Any person, *whether or not he is himself an adult*, may be guilty of contributing to juvenile delinquency who, as the Act states, “knowingly or wilfully (a) aids, causes, abets, or connives at the commission by a child of a delinquency, or (b) does any act producing, promoting, or contributing to a child’s being or becoming a juvenile delinquent or likely to make any child a juvenile delinquent.”

Just what facts support a conviction for the offence of “contributing” has been the subject of much discussion. What, for example, is the meaning of “any similar form of vice”? These words could mean almost anything depending on one’s views of “vice.” Whatever they do mean, the lesson for those working with juveniles is clear. At the very least, you must not assist or abet the commission of any act you know to be an offence. The mere reception of information about an offence or a possible offence would not, however, amount to the offence of “contributing.”

Concluding Cautions

It is always dangerous to generalize about law. The more general the statement, the less exact it is. Lawyers are constantly accused of qualifying their utterances with “ifs, ands and buts.” Competent lawyers do this not out of fear that their opinion is wrong, but because the application of law depends on the facts of each case. When general questions are asked, a lawyer cannot give an answer that he is certain will fit all cases; his answer is intended to fit most cases, or typical

cases. Hence, while the general principles are set out above, it is always advisable to consult a lawyer for advice on any individual case that you think might be unusual, or about which you might be apprehensive.

One should also be cautious about regarding law as a universal criterion for the disposition of all kinds of problems. It is not. On issues of the greatest moral significance the law sometimes does not speak at all. The law will not tell you whether to go to the aid of road-accident victims. You may drive merrily on and not "get involved," for all the law cares. The issue is a moral one.

Accordingly, some of the questions that have here been discussed cannot be solved simply by reference to law. The question whether you should tell the police, or a teacher, or a priest, or the parents about a child that you believe is destroying himself with drugs is not a legal question, for the law makes no demand on you. So far as the law is concerned, you must not abet the offence but you can walk away from it.

I stress the distinction between moral and legal questions because it seems to me that there is a growing tendency to "cop out" of moral dilemmas by leaving them to the law. The law seems to be increasingly regarded as the only sure and proper reference for the disposition of social problems. This attitude confuses basic issues and stems from an ignorance of the nature of law. The law, as all lawyers know, is far from being "sure." Even when it does speak on an issue, its directives are sometimes unclear. Where it says nothing or makes no positive demand upon us with respect to a moral or legal problem, I for one do not think that the issue is therefore resolved. The area for personal decision based on moral, spiritual and humane considerations and the dictates of conscience is still a large one. The hard task of deciding on these grounds cannot always be avoided by "leaving it to the law."

L'auteur de cet article, conseiller légal de l'Addiction Research Foundation, introduit, à ce stage, un bref résumé des considérations légales concernant les mineurs. Ce résumé est principalement destiné aux membres du personnel de la fondation chargés des travaux de consultation, mais pourrait cependant représenter un certain intérêt pour de nombreux autres conseillers, professeurs et volontaires consacrés aux problèmes de la jeunesse.

Parmi les sujets discutés par Monsieur Reid figurent des rubriques telles que l'importance légale des limites d'âge variées, des contrats pour mineurs, le consentement ou la décharge des mineurs, les tribunaux d'action juvénile et la loi contre la délinquance juvénile. Des réponses sont prévues aux questions spécifiques concernant des sujets tels que le consentement des parents à donner des conseils, le délit d'hébergement, celui de contribuer à la délinquance juvénile et la manière de traiter les informations, reçues en confiance, par des jeunes gens, eu égard à des activités illégales.

Summary of a Report to the Congress on Marihuana and Health

**From the Secretary, U.S. Department of Health,
Education, and Welfare**

In this, the first detailed report to the Congress on Marihuana and Health, an attempt has been made to accurately describe the present state of our scientific knowledge concerning this issue. Not unlike a rather elaborate jigsaw puzzle, however, there are many research "pieces" whose relation to one another is not obvious. Moreover, many of the most important pieces that are required are not yet available. Some of the technical data that have been accumulated remain obscure for the present, particularly in providing a picture comprehensible to the layman. The ultimate meaning of past, present and future research will only become clearer as the various parts can be related to an emerging whole.

The purpose of this summary is to try to translate the present disparate elements into as reasonable an answer as can currently be framed to the question: What are the health implications of marihuana use for the American people?

This paper—a summary prepared by the National Institute of Mental Health of a report on marihuana and health submitted to the United States Congress early in 1971 by the Secretary of Health, Education, and Welfare—outlines current knowledge on physical and psychological effects of marihuana use.

In the preparation of this report, a wide variety of sources of information were used, including published and unpublished reports from many scientific sources, proceedings of various conferences and symposia, and government documents from a number of countries other than the United States—for example, the Interim Report of the Canadian government's Le Dain Commission. The result is a concise statement concerning the current state of knowledge in a perplexing and controversial area. For some Canadian (Metropolitan Toronto) prevalence statistics, see the last issue of *Addictions*.

It does not attempt to evaluate broader legal, economic or social issues including the consequences of law enforcement for personal marihuana use even though they are important and must be considered in a complete discussion of the overall problem.

As we examine the drug in its various natural and synthetic forms, however, it becomes evident that the deceptively simple question posed is highly complex and marihuana is not a single, simple substance of uniform type. It consists of varying mixtures of different parts of the plant, *Cannabis sativa*, with psychoactive properties ranging from virtually nonexistent to decidedly hallucinogenic in its stronger forms and at high doses. Unfortunately, much of the discussion in lay and sometimes scientific forums ignores this very basic and important fact. Most of our American experience has been limited to the widespread relatively infrequent use of a rather weak form of marihuana. Early research dealing with the drug is inevitably faulted by the fact that it is difficult to be certain just what potency material was involved and at what dose level. Although the principal active ingredient in the plant is thought to be Delta-9-tetrahydrocannabinol, much remains to be learned about the chemistry of marihuana and related substances.

Even the form in which the drug is consumed may make a difference in the consequences of use. It is quite possible, for example, that when smoked the material taken into the body differs significantly from orally consumed drug. The route of absorption, whether through the lungs or digestive tract, may also make a significant difference in the consequences of use.

Data on Use

Virtually all of the American data indicate that use of marihuana has rapidly increased over the past several years. While the number of those who have tried the substance at

some point in their lives remains a minority of the population it is continuing to increase rapidly. In some high school or college settings it is virtually certain that a majority have at least tried marihuana. By the end of 1970 about one college student in seven was using it on a weekly or more frequent basis. High school use has generally lagged behind that of colleges and universities, although in areas of high use as many as a third to a half have experimented with it. While comparable data are not available for non-school attending youth there is reason to believe that levels of use are at least comparable and for school dropouts are probably higher. In some West Coast high schools which have had relatively high levels of use there is evidence that the increase in use may be decelerating and even declining. The likelihood of continuing, persistent use over an extended period of time by large numbers is not known at the present time.

Middle-class users have tended to be individuals from higher income families attending larger, non-religiously affiliated urban universities rather than small, denominational colleges. However, as the number of users increases they become less clearly distinguishable from the more general youthful population. As use becomes more widespread there is reason to believe still younger as well as older populations are becoming involved.

Rather than being restricted to our own affluent society, marihuana use as a recent source of concern is a problem in many countries of the world. In at least three other English-speaking countries this concern has led to the appointment of commissions to examine the problem and to issue reports (Canada, England and New Zealand). While in 1956 the United Nations Commission of Narcotic Drugs estimated that over two hundred million people made regular use of cannabis, it is very likely the number is now substantially larger.

The bulk of this report makes clear that while there is much yet to be learned about cannabis, there is a substantial body of information at present available. Much of it is,

however, of only limited immediate relevance to the question of the long-term health implications of use.

Subjective Effects

A range of studies have been conducted of the drug's acute effects. As is true of other drugs, generally the effects are closely related to the amount that is consumed. There is general agreement that at the usual levels of social usage the typical subjective effects are: Alteration of time and space perception, sense of euphoria, relaxation, well-being and disinhibition, dulling of attention, fragmentation of thought, impaired immediate memory, an altered sense of identity, exaggerated laughter and increased suggestibility. Other less common effects are dizziness, a feeling of lightness, nausea, and hunger. As doses higher than the typical social dose are consumed more pronounced thought distortions may occur including a disrupted sense of one's own body, a sense of personal unreality—of being unreal, visual distortions, sometimes hallucinations and paranoid thinking. The more marked distortions of reality or psychotic-like symptoms become increasingly common if the dosage used becomes extremely high. Most users smoke to the point of "high" which they find pleasurable and at which they are able to control the effect. It is, however, difficult to predict individual reactions. Rarely, individuals may become quite anxious or panicky on even low doses. When eaten, effects are less predictable and more difficult for the user to control.

In addition to the amount of the drug that is consumed, the set and setting of use are important factors in determining marijuana's subjective effects. Set refers to the attitudes, mood, expectations and beliefs which the individual brings to the drug using experience. Setting represents the external circumstances surrounding the experience. Thus a relatively emotionally neutral laboratory setting may evoke very different responses at a given dose level than might a more

typical setting of social usage surrounded by other drug users. A situation in which the individual is depressed or apprehensive about the drug's effects differs markedly from one in which the user is more sanguine and looks forward to the drug experience with eager anticipation. The degree of personality integration, psychological rigidity and the presence or absence of psychopathology are all important contributors to one's subjective reactions to marihuana or other psychoactive drugs.

All of these psychological aspects also play a role in what is often referred to as the "placebo effect." The placebo effect is the response to the substance based not on its pharmacological activity but on the totality of expectations brought about by the set and setting of use. It is not uncommon for individuals consuming a psychoactively inert material to experience subjective effects which they erroneously attribute to an active drug. This same placebo effect may complicate results in a laboratory setting, in which the placebo is so compounded as to resemble the active material in all respects except for the presence of the psychoactive constituents. Particularly at low doses, it may be difficult to be certain to what extent an effect is brought about by the drug itself or placebo effects.

Physiological Effects of Acute Marihuana Use

Physiological changes accompanying marihuana use at typical levels of American social usage are relatively few. One of the most consistent is an increase in pulse rate. Another is reddening of the eyes at the time of use. Dryness of the mouth and throat are uniformly reported. Although enlargement of the pupils was an earlier impression, more careful study has indicated that this does not occur. Blood pressure effects have been inconsistent. Some have reported slightly lowered blood pressure while others have reported small increases. Basal metabolic rate, temperature, respiration

rate, lung vital capacity and a wide range of other physiological measures are generally unchanged over a relatively wide dosage range of both marihuana and the synthetic form of the principal psychoactive agent, delta-9-THC.

Neurological examinations consistently reveal no major abnormalities during marihuana intoxication. However, some investigators have found a small decrease in leg, hand and finger strength at higher dosages. Some decrease in hand steadiness and the ability to maintain balance occurs as dosages increase. Although users often report enhanced sensory awareness in the drugged state, objectively measurable improvements in visual acuity, brightness discrimination, touch discrimination, auditory acuity, olfactory threshold or taste discrimination have not been found. Some small changes in electroencephalograph (EEG) findings have been detected but the significance of these results is in doubt.

From the standpoint of lethality, cannabis products must be counted among the safer of the drugs in widespread use. Death directly attributable to the drug's effects is extremely rare even at very high doses.

Acute Psychotic Episodes

Acute psychotic episodes precipitated by marihuana intoxication have been reported by a number of investigators. These appear to occur infrequently, usually at high dosages, but may occur, even at levels of social usage, in particularly susceptible individuals. Heightened susceptibility appears to be more likely in those who have previously had a marginal psychological adjustment especially in the presence of excessive stress.

Intellectual and Motor Performance

Changes in time sense have definitely been shown to take place during marihuana intoxication. There is a tendency to

overestimate the passage of time particularly while engaged in some activity.

A wide range of tests of intellectual functioning and of psychomotor performance (the ability to precisely coordinate sensory perception and muscular performance) have been carried out under conditions of intoxication. As might be expected, the degree of impairment is dose related. It also varies during the period of intoxication.

Generally, the more complex and demanding the task to be performed the greater is the degree of impairment. Simple and very familiar tasks such as reciting the alphabet or repeating a brief series of numbers are least likely to be affected at relatively low dose levels. As the task becomes more complicated, however, decrements in performance do become apparent. Inexperienced users tend to show greater decrements than do experienced marihuana users.

Because of the importance the automobile assumes in our society, the effect of marihuana on driving performance is of fundamental interest. One widely reported finding using a driver simulator was that the performance of marihuana using drivers was equal on the average to that of a non-intoxicated control group. It is, however, important to note that this was based on a single study of intoxicated drivers under test conditions that might be expected to be highly motivating. In addition, half the drivers in the experimental group did more poorly than did the control group. This suggests that the ability to compensate for the effects of marihuana—to suppress the “high”—may differ markedly from individual to individual. The relevance of this work to more typical driving conditions is not known.

It is noteworthy that in another series of studies not directly concerned with driving, marihuana intoxicated subjects consistently answered, “No!” when asked, “Do you think you could drive a car now?”. Preliminary results of a

study of attention skills believed to be among the best predictors of actual driving performance have shown performance decrements under marihuana use similar to those found when drivers have consumed moderate amounts of alcohol. Additional much needed research on driver performance and other complex motor tasks is currently in progress.

Marihuana users consistently report that their short-term and immediate memory while under the influence of the drug is interfered with. Systematic research evaluation generally confirms this. More complex functions such as learning a number code, using such a code for encoding a series of numbers, understanding a written paragraph or spoken speech are all interfered with even at the moderate levels of typical American social usage. This is believed to reflect difficulty in retaining, coordinating and indexing over time those memories, perceptions and expectations demanded by the task being performed.

Marihuana and Birth Defects

A basic concern with any drug substance coming into wide use is the possibility that it may affect fetal mortality or fetal development (i.e. may be teratogenic) in such a way as to bring about abnormal offspring of pregnant users. It may also conceivably affect unborn generations by causing chromosomal changes (i.e. may be mutagenic) that persistently alter the genetic heritage. Thus far there is little evidence that marihuana or related materials do this. While preliminary studies of the effects of injecting relatively large quantities of cannabis or related substances have found some indication of fetal abnormalities in rats, other researchers have been unable to duplicate such findings. There is no evidence to suggest that marihuana use in humans affects fetal development. Despite the present absence of such evidence, it is obviously unwise for anyone to use any drug of unknown teratogenic

or mutagenic properties during the child bearing years. Use during pregnancy is particularly unwise.

Effects of Long-term Chronic Use

While a good deal is known about the acute effects of cannabis use and the laboratory findings to date generally correlate well with user reports, much less is known about the implications of long-term chronic use. In few experimental studies has marihuana been administered to humans for extended periods. These periods have been limited at most to a few weeks. In addition, earlier studies of both acute and chronic use have provided no indication of the exact amounts of psychoactive material involved and so it is difficult to compare those findings with those of contemporary research. Over a period of just under six weeks, one investigator found only small physiological changes when individuals were permitted to consume the drug freely in whatever quantity they chose. A daily mean of 17 cigarettes each was consumed by this group of prisoners. There was some mild confusion under those conditions of continued intoxication with slight impairment of performance on general intelligence testing during the period. While mild changes in electroencephalograph findings were found, these returned to normal five days after discontinuing the drug. There was no evidence of withdrawal effects (i.e. physical symptoms precipitated by discontinuing the drug) after this duration of use.

It should be emphasized that early attempts at evaluating the effects of long-term use of cannabis suffer from multiple scientific defects. Whether they tend to indict or to absolve cannabis from causing chronic physical or psychosocial consequences, it is difficult to be certain of the validity of their observations. The Indian Hemp Commission Report, for example, although a careful, systematic study for its day (the 1890's), can hardly be regarded as meeting modern epidemiological research standards. Subsequent studies such

as those of the group appointed by the then Mayor LaGuardia in New York City can also be easily faulted for their scientific deficiencies. While psychoses presumably resulting from heavy cannabis use have been reported, these studies do not generally meet modern scientific standards.

The fact that there are many worldwide reports of heavy, chronic cannabis use resulting in loss of conventional motivation and in social indifference is of particular interest in that there are now some reports of somewhat similar findings among American heavy users of marihuana. Unfortunately, American use patterns are frequently contaminated by the use of other drug substances, making interpretation difficult. It is not certain to what degree this "amotivational syndrome" is the result of marihuana use *per se* or of a tendency for those who lack conventional motivation to find drugs unusually attractive. If one confines his use of the term to a description of the present American scene one must conclude that present evidence does not permit the establishment of a causal relationship between marihuana use and the amotivational syndrome. There is, however, increasing evidence that frequent, heavy marihuana use is correlated with a loss of interest in conventional goals and the development of a kind of lethargy. Research in humans is being conducted in an attempt to determine to what extent this observed correlation is due to alteration in brain functioning.

The issue of long-term mental deficit is an exceedingly complex one in which the lack of sufficiently sophisticated methodology may be crucial. The problem of determining harmful effects of chronic use and especially of psychological harm as a result of using a drug substance whose effects are not dramatic is very difficult. Unless the type of deficit is especially distinctive, it is likely that the same symptoms will be exhibited by many non-drug users. Furthermore, unless the harm done to the user is so gross as to be noticeable in a high percentage of users, it may readily be attributed to other

factors such as poverty or poor nutrition. Tobacco furnishes an apt example of the difficulties encountered in demonstrating even physical hazards of use. It was only after many years of use by a substantial segment of the population that the role of smoking in the development of various types of diseases was recognized. It should be noted that concern has been expressed that marihuana when smoked in large quantities might be expected to have similar carcinogenic effects to those associated with cigarette smoking. There is, however, no present evidence to suggest that marihuana is cancer-producing.

Marihuana and the Use of other Drugs

It is generally conceded that marihuana use does not necessarily lead directly to the use of other drugs. On a worldwide basis there is little evidence of a progression from the use of marihuana to that of opiates or hallucinogens. However, those who find use of marihuana highly attractive, may also be attracted to the use of other drug substances which may be popular among their peers. These may include stronger hallucinogens, amphetamines and the opiates. While it is true that a high percentage of heroin addicts have used marihuana as well, most marihuana users both here and abroad do not appear to be attracted to the use of heroin.

Future Research Directions

It is evident that much remains to be learned about marihuana, hashish and related materials. Little is as yet known about the implications of chronic use particularly at lower dose levels and less frequent intervals. Although much can be learned from animal research, in the final analysis the most crucial information with respect to long-term human use can only be obtained by careful observations of chroni-

cally using groups here and abroad. Such research is currently being carried out.

It is important that we learn more about the possible interactions between marihuana use and that of a wide range of other drugs. This includes not only such drug substances as caffeine, tobacco and alcohol, but also other drugs of abuse and a wide spectrum of therapeutically employed drugs. As use of marihuana comes to include a wider spectrum of the population it is important that we learn its effects on those whose physiological functioning is to some degree impaired or who suffer from physical or psychological disabilities. Such effects must be studied over a wide dosage range and in various use patterns.

From a psychosocial point of view it is essential that we come to better understand the different patterns of drug use, their implications for social functioning and those factors which contribute to such use. These include parental attitudes, child rearing practices and peer pressures as well as those aspects of subcultural and cultural practices that may affect use. Finally, it is imperative that we determine what are more effective prevention and education techniques that serve to avert drug abuse of all types including that of marihuana.

Ce sommaire des connaissances actuelles, concernant les conséquences possibles de l'utilisation de la marihuana sur la santé, fut tout d'abord préparé puis publié par l'Institut National des Maladies Mentales, d'après un rapport soumis au Congrès vers le début de l'année 1971, par le secrétaire du ministère de la santé, de l'éducation et du bien-être aux Etats-Unis.

Les auteurs ont clairement déterminé que, bien qu'une somme considérable d'informations soit désormais disponible sur la marihuana,

ses aspects particuliers tels que les implications, à long-terme sur la santé, de son utilisation demeurent encore obscurs.

Bien que peu de changements physiologiques aient été constatés chez les utilisateurs de la marihuana, plusieurs effets subjectifs ont été enregistrés. Ceux-ci varient depuis un sentiment de bien-être ou d' "excitation" à des symptômes similaires de dérangement mental, différents selon l'utilisateur, la dose et l'atmosphère dans laquelle elle a été consommée. Des manifestations d'aliénation aigüe ont été également rapportées, bien que non fréquentes et ne survenant qu'après consommation de doses élevées. Chez des individus particulièrement sensibles, cependant, ces mêmes manifestations peuvent être constatées à des niveaux moins élevés d'utilisation. Difficulté d'évaluation du temps et affectation du fonctionnement intellectuel aussi bien que de la coordination de la perception sensorielle ont été constatées pendant la période d'intoxication par la marihuana. Le degré de cette affectation varie pendant la période de l'intoxication et est relative tant à la dose consommée qu'à la difficulté de la tâche à accomplir. Plusieurs utilisateurs ont également enregistré d'affectation de la mémoire (immédiate et à court terme) pendant qu'ils se trouvaient sous l'influence de la drogue. Des recherches impérativement nécessaires sont actuellement en progrès quant aux effets de la marihuana sur les conducteurs de voitures et autres moteurs plus complexes.

Il n'a pas été prouvé que l'utilisation de la marihuana par l'être humain joue un rôle dans la mortalité ou le développement du foetus au point de causer des naissances anormales (effets tératogéniques) ou d'affecter les générations à venir par des modifications de chromosomes pouvant déranger, à la longue, l'hérédité génétique (effets de mutation). En dépit de l'absence d'une telle évidence, les auteurs sont convaincus qu'il est imprudent pour quiconque de s'adonner à quelque drogue que ce soit, aux propriétés tératogéniques et mutatives pendant les années de fertilité, et tout spécialement, pendant une grossesse. Bien que l'utilisation de la marihuana ne signifie pas nécessairement que ses utilisateurs passeront automatiquement à l'utilisation d'autres drogues, il est possible que les consommateurs de marihuana ayant trouvé satisfaction dans cette drogue seront attirés par d'autres, populaires parmi ses pareils.

En conclusion, les auteurs insistent sur la nécessité de recherches continues dans le domaine de l'utilisation chronique et à long terme de la marihuana; sur les interactions possibles entre la marihuana et les autres drogues; sur les effets de la marihuana sur des personnes physiquement ou psychologiquement faibles; et sur les différents exemples d'utilisation de la drogue, les raisons y contribuant et leurs implications pour un fonctionnement social.

The Forgotten Children

A paperback book by R. Margaret Cork

This is the second printing of a book about 115 children who were interviewed by Margaret Cork, the social worker who heads the Addiction Research Foundation's Youth Counselling Service in Toronto. All of these children came from the homes of alcoholics, and most of them have disturbing stories to tell. Miss Cork says these children need help. She believes they should have it, whether or not their parents are willing to accept help for themselves. The fact that Ontario is estimated to have some 120,000 alcoholics, many of whom are parents, points up the magnitude of the problem. 95 cents.

The Pursuit of Intoxication

A new paperback book by Andrew I. Malcolm

Dr. Malcolm has been a staff psychiatrist with the Addiction Research Foundation for eight years. His book examines the many reasons why people have used and continue to use the psychoactive drugs. These reasons are examined under five main headings: Religion, Medicine, Endurance, Extinction, and Recreation. The book not only has something to say about all drugs in current use; it also attempts to place the use of these drugs in historical perspective. \$2.50.

Drugs, Society, and Personal Choice

A new paperback book by
Harold Kalant and Oriana Josseu Kalant

This is a book designed to help people—as individuals, as family members, and as policymakers—to arrive at fully informed, balanced, reasonable decisions about drugs. Many scientists today are concerned that their work should contribute to this process. Dr. Harold Kalant is Associate Director of Research and his wife, Dr. Oriana Kalant, is a Research Scientist at the Addiction Research Foundation. They wish to provide through this book data and ways of dealing with data that will assist responsible citizens in achieving a perspective that can lead to an appropriate decision. \$1.95.

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Other Publications Available from ARF

On page 15 we listed the *Addictions* reprints that are available from Foundation offices; on pages 45 and 46 you will find advertisements for three books by ARF staff members. Listed below are publications other than the reprints that residents of Ontario may obtain from any ARF office free of charge in reasonable quantities.

ARF Research on Drugs Other Than Alcohol

Alcohol and Its Effects

Alcoholism and the Family

Appendices to the Nineteenth Annual Report (1969)

Drinking Can Be Fun

Facts About Alcohol (English and French)

Facts About Amphetamines (English and French)

Facts About Barbiturates (English and French)

Facts About Cannabis (English and French)

Facts About LSD (English and French)

Facts About Opiates (English and French)

Facts About Solvents (English and French)

Facts About Tranquillizers (English and French)

A l'intention des parents soucieux

Handbook for Parents About Drugs

If

Letter to Management Men Concerned About Alcoholism

Among Employees

LSD: Problems and Promise (English and French)

Management Can Help the Problem Drinker

Mood-Modifying Drugs Prescribed in a Canadian City

The Nature and Extent of Speed Use in North America

The Protective Drugs (English and French)

Trial and Error

The Union Can Help the Problem Drinker

Journal of Addictions

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ADDICTIONS is published four times a year by the Addiction Research Foundation, an agency of the Province of Ontario. The contents of each issue are selected on the basis of their potential interest to persons engaged in research, treatment, or education in the field of alcoholism and drug addiction. Articles in ADDICTIONS reflect the views of their authors, not necessarily those of the editors or of the Addiction Research Foundation.

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Addiction Research Foundation,
Communication Programs Division,
33 Russell Street,
Toronto 4,
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The Unforgettable Dr. Jellinek

By Robert R. Robinson

Dr. E. M. Jellinek is generally regarded as the pioneer and dean of research scientists in the field of alcoholism. Born in New York City in 1890, he died at his desk at Stanford University October 22, 1963.

When Dr. Jellinek retired in 1958 from his post as consultant on alcoholism to the World Health Organization, he became associated with the Research Division of the Addiction Research Foundation. He remained an honorary consultant to this Foundation until the time of his death.

The egg-shaped little man in the rumpled suit, his gnome-like head haloed in an awkward hearing aid holder, slumped dozing at the conference table. Discussion of a particularly complex case concluded and the assembled clinical team turned expectantly toward the master for the last word. Right on cue, Dr. Jellinek switched on his hearing aid — and his warm, twinkling smile — and chose the appropriate words, instinctively, from his incredible store of data about alcoholism and alcoholics. No computer could have retrieved the information

Mr. Robinson is Creative Director in the Communication Programs Division of the Addiction Research Foundation.

faster or with greater discrimination, nor could it have correlated the findings with such wit and wisdom and delivered them in any one of nine languages.

Dr. E. M. Jellinek, patron saint of alcoholics around the world, is the only living legend I have known. He was a character and he is unforgettable. "Bunky" lives on in the memory of the many he loved and helped, and he is certainly not forgotten by the few whom he hated and despised.

Ordinarily of a calm and sweet disposition, he could be inflamed by evidence of what he considered unethical practice on the part of a colleague who "sold out to the liquor interests." I also saw him fly into a towering rage one day when we were previewing a short movie entitled *To Your Very Good Health* that had been made by a distilling corporation. (The title of Dr. Jellinek's own classic World Health Organization film had been *To Your Health*.) There is no record of what he said to the producer, but I gathered at the time that Dr. Jellinek had made his feelings crystal clear. He certainly was not pleased either by the similarity in titles or by the content of the corporation's movie.

Not that Jellinek was a dry-eyed, pinch-nosed prohibitionist. By no means. He readily recognized the many healthful, pleasurable uses of all that was fermented, brewed, and distilled. What he objected to was the lack of objectivity, often the downright dishonesty of those who took a one-sided view of this distinctly two-sided matter. He argued vehemently against those who said that alcohol is the root of all evil and must be destroyed; but I recall his observing one day that public opinion had swung too far the other way. "After all, you can't become an alcoholic without drinking alcohol."

Although he was not a prohibitionist, Jellinek's intellectual honesty caused him to point out that alcoholism afflicted fewer Americans during the trying years of speakeasies, gangsters, and bathtub gin and immediately after, than in the freer flowing decades that have followed.

Why "Bunky"?

"Bunky" seems a strange name for a man who never talked bunk in his life. I asked him once where it came from, and he said: "Well, you see, I have always had a passion for radishes, and in our house radishes were nicknamed 'bunkies.' One day when I was pestering my father to pass them to me for the umpteenth time he ceremoniously brandished the dish and dubbed me 'Bunky.' So I've been Bunky for nearly seventy years since."

It is doubtful whether, without looking it up in official records, even his best friends would have known that his full and proper name was Elvin Morton Jellinek, M.Ed., Sc.D., and it is doubtful whether they would have known what degrees he held, nor did it matter. Bunky himself always believed that it was the person who counted, not the formal education. "Good novelists are the best sociologists," he said one day when we were talking about qualifications for carrying on research into drinking behavior. "If you really want to know about how people used alcohol in such and such a time and place, get hold of a few good novels of the period and analyze what they say about the way people drink."

A Sense of Whimsy

This funny little man, who looked very like the caricature of a research scientist depicted in his WHO cartoon film about alcohol and alcoholism, might have made a superlative novelist himself. And for all his years he would have been very much in tune with the times were he writing today, because he had a whimsical, satiric sense of humor to balance the uncompromising realism with which he saw life. Over the years he did compose innumerable fantasies and send them through the mail as his means of keeping in touch with his daughter by his first marriage. He told me one or two of the fanciful plots, but I never saw them in writing. They represented yet another side of his infinitely varied personality.

The sort of thing that set him chuckling like a delighted child was the accident he witnessed on a California through-way where a tanker truck loaded with glue overturned and spread stickum all over the pavement. "Now that *was* a traffic jam," he gleefully reported.

The Ultimate Compliment

Improbable though it might have appeared at first glance, Bunky held a peculiar fascination for women; and they for him. Indeed, prior to his last marriage in his late sixties, I recall his showing me a snapshot of a beautiful *senorita* whom he had gallantly rescued from a hotel desk clerk who did not speak Spanish. "Very fortunately I was able to translate for her," he twinkled. "Maybe we will get married when I go back to Europe." He showed the picture as proudly as any infatuated schoolboy.

The secret ingredient in his mysterious power over women was his interest in them as real people, personalities in their own right, not merely as female objects to be pursued. I know this because I have seen him focus the same degree of attention on women who were old and ugly as on their younger, prettier sisters. Totally unselfconscious himself, he was able to pay them the ultimate compliment of complete attention — seasoned with an Old World courtesy and sophistication. This same ability to concentrate on other people — men as well as women — also helped Jellinek to deal with alcoholics.

Public Understanding and Respectable Treatment

One of the early pioneers in the field who fell under Bunky's compelling influence was Mrs. Marty Mann, the dynamic founder of the National Council on Alcoholism in New York. In early 1944, five years after her own recovery, Mrs. Mann went to New Haven to see Dr. Jellinek and the late Dr. Howard W. Haggard, with him co-founder of the

Yale Center of Alcohol Studies. They listened to her vision of an organization to bring public understanding and respectable treatment to alcoholism, and they encouraged her and coached her for the job she felt she had to undertake. Today Marty gives Bunky great credit for teaching and guiding her through those difficult years.

"The Jellineks invited me to stay in their home," Mrs. Mann recalled recently. "Bunky's lectures about alcoholism and alcoholics would begin over the morning coffee. He provided me with a full university course in a matter of weeks. What a wonderful giant of a man he was."

Bunky had many achievements to his credit in alcoholism research, treatment, and education. His was the famous "Jellinek estimation formula" by which the prevalence of alcoholism in a population could be dependably approximated. He was the author of *The Disease Concept of Alcoholism* with its rational classification of familiar species of the disorder. He proposed a "vulnerability-acceptance hypothesis" to explain why alcoholics in countries that have a low acceptance of drinking are often much more upset people than those in countries where drinking is looked upon with great approval. Then there was his famous "Jellinek doodle" in which he graphically captured the life history of the predominant type of North American alcoholic. He wrote dozens of papers, conceived and executed innumerable research projects, and inspired others to carry out many times this number of significant undertakings. Most of all, however, he loved to prow through rare old books and manuscripts in Greek and Latin in search of ever more data about the symbolism inherent in the act of drinking.

The Magic in Alcohol

A prolific writer on many aspects of alcohol and alcoholism, Bunky could never quite bring himself to commit to

paper his continually evolving theories about this symbolism. He intended to do this as a major article in the Encyclopedia of Alcohol Problems upon which he was working at Stanford University at the time of his death eight years ago. Regrettably this paper was never written, and indeed the monumental encyclopedia project had to be abandoned because no successor could be found who was capable of marshalling the depth and breadth of knowledge that was his.

"People try to explain the ancient custom of drinking entirely on the basis of what it does *for* them — relieving anxiety, reducing tensions, et cetera, et cetera," he said once in my presence. "This is all very well as far as it goes, but it does not satisfy my question: what is the *meaning* of this for man?"

Ranging through ancient mythology, Bunky could cite dozens of references to alcoholic beverages as "the stream of life," equating first wine, then beer, and finally distilled spirits with blood itself. Thus did alcoholic beverages acquire magical, medicinal, comforting, even nourishing properties and people become persuaded that they were "good for you" long before the advent of modern advertising.

"The Madison Avenue boys don't have to strain their imaginations very much," Bunky wryly observed. "They are only taking recourse to something that man has believed for thousands of years — that taking in the alcoholic beverage is symbolic of ingesting power. And this is reinforced by the actual physiological effect of ingesting a moderate quantity of alcohol. You actually feel an expansion of the chest, a new strength, a surge of power!"

The Profanation of Ritual Drinking

Then there is the symbolism of drinking together. Bunky himself seldom drank, because he said he enjoyed conversation too much to muddle his wits with whisky; but he recognized the importance of sharing a drink with others. He likened it to the primitive practice of strangers who would

scratch their wrists then hold them together to let the blood intermingle and take away the threat of strangeness. The sharing of a drink is an act of identification.

Bunky was tremendously excited one day to come across an old document of London Jewry, dated from the end of the thirteenth century, in which the Rabbi of London said to his people: "Of course you cannot eat with the Gentiles because of our dietary rules, but do not refuse a drink. That would be going too far!"

This same idea, according to Jellinek's way of looking at it, underlies the feelings of many people down to this day who fancy themselves insulted and outraged if a drink is refused, no matter how politely. "He is not going to drink with me; I am not good enough for him; he refuses to identify with me," is the way Jellinek summed up the reaction.

Just two years before his death, at a time when Dr. Jellinek was a consultant to the Addiction Research Foundation of Ontario, I escorted the old gentleman to London, Ontario to address a special studies day at St. Peter's Seminary. It was an occasion he enjoyed immensely: he found himself surrounded by learned fathers fresh from classical studies in the Vatican, and they fully appreciated his erudition. (They also enjoyed his sense of humor — one which ranged all the way up to the present and included a nodding acquaintance with Pogo and his animal friends of Okefenokee swamp — a subject we discussed at lunchtime while a hungry seminarian dutifully intoned passages in Latin from Medieval texts.)

At the conclusion of his discourse on symbolism at the Seminary, Jellinek spoke of the profanation of what had been ritual drinking down through the ages. As this profanation increases, the utilitarian aspect of drinking becomes more pronounced, excess becomes more pronounced, and with that there appears the phenomenon of alcoholism. When alcoholism appears we don't know what to do with it because, in Jellinek's view, we are dealing with an ancient and honorable custom which has very deep meaning, which has done very

many good things for us. Suddenly we see it doing very bad things, so we conveniently attribute this to the badness of the person who drinks excessively. We hesitate to interfere with a substance that has become part and parcel of our customs and behaviors. Thus is alcoholism a problem for us.

Whereof One Can Speak . . .

For all his scholarship — and a colleague once remarked that he could have occupied a professorship of classics or history with the same brilliance and grace with which he occupied his professorships of psychiatry — Bunky never lost his characteristic humility. Nor did he ever hide behind scientific jargon in his lectures or his writing. He talked human language about human problems.

A favorite quotation of his was from a little book by Professor Wittgenstein of Oxford University. It concluded with these words: "Whereof one can speak, one can speak in simple and unmistakable terms. Whereof one cannot speak, thereof one must be silent."

This modest, unassuming little giant was magnificently qualified to speak loudly and clearly about alcoholism. He entered this field in the late 1930's when a newly formed Research Council on Problems of Alcohol commissioned him to undertake a critical review of the medical-psychological literature on the effects of alcohol on the individual. This exhaustive review was published in 1942 under the title *Alcohol Addiction and Chronic Alcoholism*; and in the process of preparing it, Jellinek had accumulated some 3,000 coded abstracts — cornerstone of an ongoing scientific instrument known today as the Classified Abstract Archives of the Alcohol Literature.

In 1951 he became the World Health Organization's first consultant on problems of alcohol and drug addiction, and over the next five years he travelled more than 300,000 miles assisting with programs of research, treatment, and education

throughout the world. As Dr. Joseph Katz of the Institute for the Study of Human Problems at Stanford said in a tribute read in the university's Memorial Church on the Sunday following Bunky's death: 'He was equally at home in Grenoble, Leipzig, Budapest, and the jungle.' His insatiable scientific curiosity had taken him virtually everywhere.

AA and Human Nature

His scientific interest and human concern frequently took him to meetings of Alcoholics Anonymous — as a non-alcoholic friend. He was much beloved by the late Bill Wilson, co-founder of that fellowship, and by thousands of rank and file members, and he often shared good stories with them.

One that he loved to tell because it illustrated a foible of human nature — alcoholic or otherwise — runs like this:

Once upon a time a member of AA was shipwrecked and washed ashore on a deserted island. He was a resourceful man and he managed to get along quite well for several months until a passing ship was attracted by his distress signal and put out a boat to investigate. Before the life-boat crew carried him back to their ship, the AA man insisted on showing them his camp. "This hut is my AA meeting place," the man explained. "I couldn't have survived without coming here each day."

A ship's officer pointed to another lean-to on the other side of a sand dune and asked what that was.

"Oh, that's for the AA group I don't attend," he said.

Le Dr. E. M. Jellinek est généralement reconnu comme étant le pionnier et le doyen des savants faisant des recherches sur l'alcoolisme. Né à New York en 1890, il est décédé à son bureau de l'université Stanford le 22 octobre 1963.

Lorsque le Dr. Jellinek a pris sa retraite de son poste d'expert conseil en alcoolisme auprès de l'organisation mondiale de la santé,

en 1958, son intérêt se porta vers la division de la recherche de l'Addiction Research Foundation. Il demeura expert conseil honoraire de cette fondation jusqu'au moment de son décès.

Cet article est un mémoire personnel par Robert R. Robinson qui a travaillé de concert avec le Dr. Jellinek à la fondation. En plus de décrire sa personnalité et son impact sur son entourage, M. Robinson explique quelques-unes des théories sur le symbolisme de la boisson ainsi que sur l'usage et l'abus d'alcool dans notre société.

Reprints of Addictions Articles Available

Reprints are available of many of the articles that appear in *Addictions*. If you are a resident of Ontario and would like to receive, free of charge, one or more copies (any reasonable quantity) of any of the reprints listed below, please contact your nearest ARF office. The telephone number will be found on the inside front cover of *Addictions*.

Alcohol Use and Alcoholism by Jan de Lint and Wolfgang Schmidt.
Alcoholism: A Merry-go-Round Named Denial by Joseph L. Kellermann.

ARF Summary with Comments on the Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs.

Barbiturate Abuse in Alcoholics and Young People with Other Drug Problems by Paul Devenyi.

The Extent of Drug Use in Metropolitan Toronto Schools: A Study of Changes from 1968 to 1970 by Reginald G. Smart, Dianne Fejer, and Jim White.

Illusionogenic Crisis and Effective Intervention by Wally Seccombe.

Legal Considerations in Counselling Young People by Robert F. Reid.

Marihuana and Health from the U.S. Department of Health, Education, and Welfare.

Marihuana, the Experts, and the Public by Oriana Josseau Kalant.

Preliminary Brief to the Commission of Inquiry into the Non-Medical Use of Drugs from the Research Division of the ARF.

The Role of the Union in Industrial Alcoholism Programs by James A. Belasco, Harrison M. Trice, and George Ritzer.

Traffic Accidents of Alcoholics by Reginald G. Smart and Wolfgang Schmidt.

MDA And Its Relationship To Other Psychedelics

By Robert N. Richards

Youth counsellors, teachers, physicians, nurses, parents, and others who have been concerned with young people and drugs over the past few years have all been subjected to a barrage of new terminology. Typical of this new language are terms like trip and freakout and drug names like N,N-dimethyltryptamine, trimethoxyphenylethylamine, and 3,4-methylenedioxymphetamine. Fortunately, these drug names can be translated into shorter designations: DMT, mescaline, and MDA, respectively. Unfortunately, just being familiar with manageable names for such drugs is very often not enough. What is needed, usually, is a straightforward and not too technical description of some of these, presented in such a way as to show their relationship to other drugs that are similar in their effects. What Dr. Richards has done here is to give a short account of one of these — MDA — and to point out its resemblances to other drugs of the same general kind. Editor.

MDA is chemically related to certain naturally occurring drugs, such as mescaline, and to various chemicals present in the body, such as adrenaline. It is also related to synthetic chemicals, such as the amphetamines. It is generally classified with the psychedelic or hallucinogenic group of drugs. Currently, no definite medical indications for the use of MDA exist, and its legitimate use is restricted to investigators. However, it has been used as a "street drug" by a small number of young people.

Broadly speaking, the psychedelic drugs, including MDA, act on the brain to produce a variety of subjective experien-

Dr. Richards is a physician in private practice in Toronto. For a period of 16 months in 1970 and 1971, he served as Medical Consultant to 12 Madison, a youth project funded by the Addiction Research Foundation of Ontario and the Toronto YMCA.

ces. The type of reaction produced will vary greatly with the dose, the user, the circumstances, the user's expectations, and his previous experience with hallucinogenic drugs. The same user, on different occasions, may have very different types of reactions to the same psychedelic drug, much as he might with alcohol. This variation is even more pronounced, however, with the psychedelic agents.

Typically, psychedelic drugs produce changes affecting the user's senses and moods. There may be distortions in the way he sees, feels, hears, or tastes. There may be distortions in the way he sees his own body and in the way he recognizes the passage of time. Occasionally, a user may even see things that aren't there or "hear things." The user's emotions are often affected. There may be increased self-awareness, a feeling of oneness with the world, a feeling of love, euphoria, freedom, or ecstasy; or there may be feelings of despair, hopelessness, depression, or even paranoia.

Although MDA and other psychedelic drugs can produce a variety of phenomena, one or more of the components will usually occupy a major role in any given episode. If the experience is predominantly pleasant, then it is a "good trip." If it is unpleasant, the user can be filled with anxiety or panic, and it is a "bad trip." All the psychedelics are capable of producing both good and bad trips. During a trip, there may, in occasional cases, be foolish behavior leading to accidents or other hazards. However, the immediate physical effects of psychedelic agents are usually not pronounced or harmful.

Treatment for adverse reactions to MDA is the same as for other psychedelic agents. It consists of "talking down" in a comfortable, empathetic environment and the addition of appropriate chemical intervention if required.

Psychedelics in Historical Perspective

MDA is a relatively new, synthetic drug; but many plant-derived psychedelics have been known to man for centuries

For example, mescaline, which is found in the peyote cactus that grows in areas of Mexico and the southern United States, has been used by certain native tribes for centuries. Psilocybin, another psychedelic drug, is found in some Mexican mushrooms. DMT and DET are the active ingredients of snuffs that have long been used as psychedelics by many South American tribes. Common kitchen nutmeg has also been used as a psychedelic agent for hundreds of years.

New horizons opened with the discovery by Hofmann in 1944 of the psychedelic properties of a synthetic drug, LSD (lysergic acid diethylamide), that had much the same effects as mescaline. LSD captured the public imagination in the early 1960's partly because of the enthusiastic interest in it of Dr. Timothy Leary and the widespread reporting of this in the popular press. Public interest was also stimulated by the fact that LSD is tasteless, colorless, and odorless, and that incredibly small doses of it produce psychedelic effects. With high doses, however, other psychedelic drugs may produce essentially the same effects as LSD. (Whisky is more potent than beer, but 15 drinks of beer are more intoxicating than one drink of whisky.)

It is interesting to note that the hallucinogenic experience can sometimes be produced with drugs other than members of the so-called psychedelic group. Under proper conditions of dose, user, and circumstances, the reaction may be obtained with amphetamines, sleeping pills, alcohol, and a variety of other drugs. The same results can sometimes be produced by means other than drugs, such as sleep deprivation, sensory deprivation, intense meditation, and religious experience. In some instances, certain mental illnesses can produce identical effects.

Variations with Dose, User, and Circumstances

MDA was first studied in 1933 by Dr. Gordon Alles, who experimented with the effects of low doses of the drug on

himself. He found that it produced a pleasant alteration in mood with less of the distortion of sensation that he associated with other hallucinogenic drugs such as mescaline. Other investigators used MDA in psychotherapy and reported that it helped communication and expression of feelings. Again, there was little sensory distortion. There were also no significant physical symptoms except for dilated pupils.

Because of these initial reports, MDA began to be known popularly as a drug that would give a particularly pleasant and tranquil psychedelic experience — a “love trip” — and MDA itself was called “the love drug.” However, subsequent investigators demonstrated that with the appropriate dose, user, and circumstances, MDA could produce the same type of psychedelic experience that was seen with other drugs of its class such as LSD and mescaline.

Problems in Studying Street Use

MDA has been found in Ontario. In 621 illicit drug samples collected in Ontario between January, 1969, and February, 1970, Addiction Research Foundation investigators found 27 samples of MDA. It was usually in the form of a white powder and was being used orally and intravenously, and also sniffed through the nose. (There were also 11 samples alleged to be MDA that turned out to be other drugs.)

In talking with young drug users in Toronto, however, it has been impossible to be certain, from their accounts, which psychedelic agent they have taken and thus to observe the effects of specific drugs. In most instances, the effects of what they claim is MDA have been indistinguishable from effects that apparently are the result of taking other psychedelics (or even other drugs). Information obtained from drug users must be confirmed in a laboratory if it is to have any value.

The situation is complicated by the fact that the youthful drug user can be chemically promiscuous. Various substances

are often taken in combination. In cases in which a user has taken MDA and some other drug, some effects may be due to MDA, some to the other drug. This promiscuousness undoubtedly causes certain effects to be wrongly ascribed to various drugs by users themselves. It also adds to the difficulty of determining scientifically the specific action of MDA and of some other drugs as well. It is interesting, however, that in the few cases in which MDA alone has been taken and has been identified by laboratory tests, there has been a high degree of similarity between the effects of MDA and those of other psychedelics.

Need for Research into High Dose Toxicity

Currently, it appears that the physical effects of MDA, in dosages used on the street, are quite mild. Dilated pupils have been the only constant feature in the laboratory. While it also appears that MDA — like many other drugs that act on the brain, including other psychedelics — can contribute to behavior that could lead to dangerous activities, it is questionable whether there are as yet any well-documented reports of deaths due to behavior produced by MDA.

Insofar as physical effects at high doses are concerned, we know very little. There are no accurate studies available of high dosage users of MDA. Although many other psychedelic agents are known to have been consumed in huge quantities, few, if any, deaths have been proven to have occurred as a result of their toxic effects on the body. The newspapers have frequently referred to deaths of this kind as being due to MDA, but this has not yet been proven. Research into the physical effects of MDA, including its toxicity at high doses, is needed.

Le Dr. Robert Richards, un médecin de Toronto, qui a servi à titre de médecin consultant pour 12 Madison, un projet pour la jeunesse,

discute de la MDA, une drogue qui est apparentée aux drogues telles que la mescaline et les amphétamines et aussi aux produits chimiques retrouvés dans le corps humain, tels que l'adrénaline. Le Dr. Richards rappelle brièvement l'histoire de la relation entre hallucinogènes et l'histoire de la MDA. Les effets de la MDA prise en petites doses sont relativement faibles. Toutefois, prise en plus grandes doses, pour certains usagers, et sous certaines circonstances, la MDA peut produire le même genre d'expériences psychédéliques que les autres drogues hallucinogènes. Peu est connu des effets et de la toxicité de la MDA prise en grandes doses, et plus de recherches sont nécessaires.

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Addicts and Pushers

By Gordon K. Stewart

The LeDain Commission describes addiction as "an ambiguous term with various meanings in different situations" and goes on to say that it "usually implies a strong psychological dependence (or compulsion to use) and/or physical dependence (withdrawal symptoms in abstinence) and, often, a tendency to increase the dose (tolerance)." On that basis most of us are, in some sense, addicts. I am addicted to tea. Most clergy are addicted to talking. We have a strong psychological dependence on it. If you shut us up we have withdrawal symptoms. We start to squirm and fuss and inwardly figure out how much wiser we are than the person who is doing the talking at the moment. And, given half a chance, we have a strong tendency to increase the dose.

Some people are addicted to work, some to cigarettes, some to the shot of adrenalin they get from jumping out of aircraft and skydiving. Some are hooked on money, some on alcohol, some on marihuana, some on respectability, some on their peer group, and some on speed and heroin. Some are even hooked on religion. It is significant, I think, that one group of religionists have even borrowed the addict language, call themselves "Jesus freaks," and talk about being "stoned on Jesus."

Rev. G. K. Stewart was until recently an Associate Secretary of the Board of Evangelism and Social Service of the United Church of Canada. He has now taken up new duties at Sackville United Church, Sackville, New Brunswick. This article has been adapted from an address given at a meeting in November, 1970, of the Leaside Home and School Association, Toronto. A more condensed adaptation of the same address later appeared in *Man Fully Alive*, the 46th Annual Report of the Board of Evangelism and Social Service, published in 1971. The present version is presented here with permission of Mr. Stewart and of the Board.

Now I don't mean for a minute that we can just put all these things in together and talk about them as if they were all the same. They certainly are not. But I am pushing this business of the range and variety of addictions or dependencies because it seems to me we need badly to get rid of a good deal of self-righteousness if we are ever going to understand, much less be heard by, those whose addictions are different from ours. And this, it seems to me, is the significant phrase. We must stop thinking of those caught up in the drug culture as weird creatures from an alien world and start thinking of them simply as those who are like ourselves but whose addictions are different from ours.

Pushers in Two Cultures

We have slipped into a situation where our society is divided into two cultures, each with its typical drugs and symbols and each damning the sins of the other one. On the one hand we have the hip culture, with an almost universal acceptance of marihuana and an openness to other illegal drugs. On the other we have the square culture with an over 75% acceptance of alcohol and an openness to sleeping pills, tranquillizers and, in general, anything legally usable to make life seem less painful or threatening, or to enable us to forget about it altogether. On the one hand we have the swinging culture doing its own thing, from rock music, to nudity, to free love, to witchcraft, and setting itself apart symbolically from a society it rejects by its hair styles and its clothing. On the other hand we have an establishment culture which still believes in reason, and even believes it is reasonable, which believes in duty and authority, and which finds security and value in the family, in public order, and even in traditional worship.

The addicts and pushers are not all "over there." In a real sense we are all addicts. In an even more real sense we are all pushers. We push the things we happen to be

hooked on. We finance our hockey broadcasts and part of our government by pushing alcohol. Until we scared ourselves, we pushed cigarettes in similar ways, without seriously questioning ourselves about the issues involved. We push patent medicine and pain relievers and food additives and sleeping pills and what have you. In a broader sense we push whatever pays. We push credit even upon those who can least afford it. And if you don't think that can lead to addiction you have never dealt with those who have been hooked by it. We push sales of material goods nobody really needs, and feel we have to for the good of the economy. We *also* are pushers, and some of the results of our pushing are pretty ugly.

Social Event or Crime?

It is in that kind of context, I think, that we have to understand the present furore about marihuana. As a natural-born square I find marihuana interests me not at all—but then, it is not my symbol. To many young people it *is* a symbol, and when we oppose it we are not seen as protecting public welfare but quite simply as defending our culture against theirs. And they have a point. There is no evidence that I have been able to discover that marihuana is any more damaging than alcohol. But then alcohol is *our* drug and we will have it even at the cost of some 300,000 alcoholics—a rough figure for Canada. Marihuana is *their* drug and that's different. A juice party is a social event. A pot party is a crime. Now I am not arguing for the legalization of marihuana, but I am arguing for a single standard and some kind of consistency so that a boy on an experimental high on marihuana is not branded a criminal while his father can be soused on gin and thought of as a community leader. To me that is a matter of simple justice, and I don't think we are going to get far with our drug problems until we can get free enough of our cultural hang-ups to correct it. But—and this is where I part from the apologists of the drug culture—

when we have done that, I don't think we will have advanced an inch in dealing with the problem of addiction.

Lonely and Normless People

Addiction manifests itself differently in our different cultures and sub-cultures, but it is in all of them and its roots run down to the common human element in them all. The addict is the "proper stranger" (to borrow the title of a piece of rock music). In whatever culture, he is typically the man or woman, the boy or girl who has lost his (or her) way. He has been caught in what the LeDain Commission calls a sense of "anomie," a sense of normlessness. He is truly alone. With or without drugs, he is without direction. And there are more people in this situation than we realize. I suspect they are all around us, in all sections of society.

The truth is much of our age has lost direction, as it has lost faith in our own humanity and worth. We have accepted too easily pictures of ourselves as naked apes or mad scientists. Then we have become angry, as frightened people do, and we have tended to lash out at what seems to have reduced us to what we think we are. Our youth have often lashed out at us, at our insensitiveness and our injustices. We, in turn, have lashed out at them, at their clothes, at their hair, at their drugs, at their apparent threat to our old certainties. By entrenching ourselves in our respective sub-cultures we have both felt better, and we have been able to quiet our fears with our respective drugs and to vent our angers on one another. But we have both missed the issue.

A Sense of Splendor

The only final answer to addiction is such vision and purpose as makes freaking out just seem absurd. At bottom addiction is a spiritual problem. There are remedial things to be done, of course—clinics, counselling, and other things of

that sort. And there are legal things, too. Our law should be amended with all possible speed to eliminate its most glaring inequities. I don't think the cry for the legalization of marijuana in itself contributes anything, but I do think the inequity between our treatment of the youngster on pot and his father on alcohol should be removed immediately. Meanwhile we should go to work on a thorough review of our laws relating to all drugs and seek to assign to them controls appropriate to their varying real dangers. At the same time I believe the advertising and promotion for profit of any drug—and I include patent medicines, alcohol, and tobacco—should be banned forthwith. At best such promotion is an encouragement to self-prescription and at worst an incitement to addiction.

But until we regain the sense of splendor of being human, and until we see that splendor in every other person—until in Christian terms we regain the vision and the hope of those called to be the children of God—we shall go on copping out into our chosen and mutually aggravating addictions until we have become the naked vicious apes we mistakenly imagined that we were.

Time to Start Listening

In the song I referred to, the “proper stranger” is asking direction. I don't think he is asking the way to a drug clinic. His problem is deeper than that. Maybe it isn't even an addict talking. Maybe the loneliness, the lack of direction, are just those of the average kid, or man, or woman—maybe they are those of our whole world. We had better start listening.

Dans cet article, le Révérend G. K. Stewart, ministre de l'Eglise-Unie, discute d'une grande variété d'attitudes et d'activités qui pourraient être décrites comme “intoxication”. Il voit des gens qui sont pris dans l'engrenage de la drogue comme des gens dont “l'intoxication” est différente de celle de la majorité du monde. Il compare

le monde "sérieux" à celui de la drogue, et fait remarquer que dans chacun, il y a les isolés et les indécis qui utilisent une ou plusieurs drogues pour apaiser leurs craintes.

M. Stewart suggère que le problème en est un spirituel et que la réponse est dans le sentiment d'avoir un but dans la vie et dans la grandeur d'être humain.

Other Publications Available from ARF

On page 10 we listed the *Addictions* reprints that are available from Foundation offices; on pages 35 and 36 you will find advertisements for three books by ARF staff members. Listed below are publications other than the reprints that residents of Ontario may obtain from any ARF office free of charge in reasonable quantities.

ARF Research on Drugs other than Alcohol

Alcohol and Its Effects

Alcoholism and the Family

Appendices to the Nineteenth Annual Report (1969)

Drinking Can Be Fun

Facts About Alcohol (English and French)

Facts About Amphetamines (English and French)

Facts About Barbiturates (English and French)

Facts About Cannabis (English and French)

Facts About LSD (English and French)

Facts About Opiates (English and French)

Facts About Solvents (English and French)

Facts About Tranquillizers (English and French)

A l'intention des parents soucieux

Handbook for Parents about Drugs (English, French, and Italian)

If (information for those who need help with drug or alcohol problems)

Information about Alcoholics Anonymous and A1-Anon Family Groups

Letter to Management Men concerned about Alcoholism among Employees

LSD: Problems and Promise (English and French)

Management Can Help the Problem Drinker

The Nature and Extent of Speed Use in North America

Trial and Error (the wife of an alcoholic speaks)

Attitudes that Facilitate or Hinder the Treatment of Alcoholism

By Joan Curlee

Naturally we desire to explain why people drink in an excessive, addictive manner. In seeking a "cause" for this behavior, it is easy to fall into an exaggerated reductionism. For example, I know a psychiatrist who assumes that any alcoholic can be considered an "infantile personality," with all that implies about dependency problems, other difficulties in object relationships, sexual immaturity, and general ego inadequacy. If he deals with a patient who has a history of a drinking problem, he assumes that his patient exemplifies an infantile personality, and treats him accordingly.

Other well-trained and experienced people have stressed other sides of an alcoholic's personality. Some assume that all alcoholics are sociopaths, who experience no guilt except their remorse when they have to bear consequences of their behavior, and who feel no genuine responsibility toward anyone. Others insist that the most common difficulty with alcoholics is their guilt—that they are people who make exceptionally high demands upon themselves and suffer agonies when they are unable to live up to these demands. Some stress the self-indulgent, irresponsible behavior of alcoholics and assume that alcoholics must be confronted with the consequences of their behavior. Others, especially Karl Menninger (1938), view alcoholism as basically self-destructive,

Dr. Curlee is Staff Psychologist at the Veterans Administration Hospital, Indianapolis, Indiana. This article is reprinted with permission from the author and from *Psychotherapy: Theory, Research and Practice*. The article appeared originally in Vol. 8, No. 1 (Spring, 1971) of that journal on pp. 68-70.

an attenuated suicide, reflecting strong guilt feelings, inward-turned aggression and despair.

Some have stressed the gregarious nature of alcoholics, and have described them as especially field-dependent, drawing their cues from their environment, especially the people around them. Yet a very sensitive, discerning book on alcoholism is called *The Lonely Sickness* (Whitney, 1965).

Still others see the alcoholic's drinking as a search for a mystical experience. Writers as different as William James and the novelist Thomas Wolfe have portrayed the role of alcohol in man's search for a sense of unity with the infinite. One psychiatrist who has worked for many years with alcoholics says she has found that her patients had, at some time early in their drinking, experienced what she calls a "cloud nine" experience, or "hitting the jackpot," in the sense of an oceanic sense of unity with the universe, and that they continue to seek this in more and more drinking. Although with the young, drugs may be serving this mind-expanding quest more than alcohol, she feels that this search for a mystical experience is an important factor in most alcoholic drinking.

Another approach stresses the social learning factors that contribute to alcoholic drinking and attempts to correct this faulty learning.

Some but not All

All these formulations help to explain the drinking of some alcoholics, but none applies to all problem drinkers. In my work with alcoholics, both in diagnostic assessment and in treatment, one thing that has struck me with great force has been the diversity among these patients. It seems to me that any attempt to apply a blanket explanation to all patients who present the complaint of excessive, uncontrolled drinking leads to errors in understanding and treating these patients. What we need, instead, is a flexibility and respect for this diversity that will enable us to see what a patient shows us,

rather than looking for ways to fit him into an etiological, or causal, theory.

Drinking Itself Interferes with Treatment

The characteristics that appear when an alcoholic seeks treatment may well be, at least in part, the result of his drinking patterns and the ensuing conflict with his environment and significant people in it. When the symptom is removed, two patients who seemed quite similar may present very different characterological pictures—pictures which would necessitate very different treatment approaches. Assessing the underlying pathology in an alcoholic who is still drinking is virtually impossible, even with the most sophisticated diagnostic methods, and may help to explain the errors implicit in simplistic, over-generalized explanations. We feel a need to treat something more basic than the symptom, but it is quite difficult to determine what that “something more basic” might be.

The assumption that when a patient's basic difficulties are resolved the drinking will take care of itself has the difficulty that addictive drinking seriously interferes with psychological treatment of underlying conflicts. In a survey conducted for the American Psychiatric Association and the National Association for Mental Health (Glasscote et al., 1967), 90% of the psychiatrists in the survey considered alcoholics to be “more difficult” or “much more difficult” to treat than other patients. In fact, 27% described them as “impossible” to treat. I suspect that most of these discouraged therapists were attempting to deal with fundamental pathology without giving much attention to the symptom—the drinking—itself.

Drinking Behavior as a Primary Problem

The fallacy implicit in this approach becomes clear when we consider the fact that therapy necessarily involves a certain

amount of anxiety which must be endured, at least long enough for it to be brought into the hour. Alcoholics, however, have learned a foolproof way of escaping anxiety; when they feel a twinge of anxiety, the remedy is readily at hand—not introspection or examination of possible transference implications of their uneasiness, but the bottle. A number of conditioning studies (cf. Solomon and Wynne, 1954) have shown the difficulty of extinguishing a well-learned avoidance response. Somehow with alcoholics an escape from anxiety-creating situations via the bottle must be prevented. In determining how this can be done, however, the diversity of the patients must be considered. Some can avoid the escape reaction by reliance upon Alcoholics Anonymous. Others can be helped to avoid this escape by use of Antabuse. For others, a period of hospitalization may be necessary to help them learn that they can tolerate anxiety for a time without any dire results. For others, still other methods must be used. But unless the drinking behavior is dealt with directly and as a primary problem, therapy will usually be fruitless. A drinking alcoholic simply cannot, as a rule, tolerate the stresses and strains of formal psychotherapy. When therapy *has* succeeded without any adjunct designed to limit the drinking, it is usually because there has been a relationship established that is strong enough to provide a control. But this is more difficult than we sometimes like to think.

Who Can Help the Alcoholic?

Our emphasis on underlying pathology implies that only a psychiatrist, psychologist, or perhaps a social worker can *really* treat an alcoholic. This has a ring reminiscent of the statement one formerly heard frequently in Alcoholics Anonymous: "Only an alcoholic can help an alcoholic." But the statement is heard much less frequently in AA today, and Bill W., one of the founders of AA, has implored, "Let's be friendly with our friends," and has urged AA members

to utilize any treatment modality that might be needed or useful in a particular case. Perhaps he has gone beyond many professionals in recognizing the implications of the tremendous diversity among alcoholics.

There is a great deal of evidence that people can and do recover without psychiatric attention to their underlying conflicts. Some of the people in AA, for example, have made recoveries any therapist would be proud to see in his patients, without psychiatric attention. Psychiatric treatment for all alcoholics cannot be made available even if it were clearly the treatment of choice. Unfortunately, too, the attitude that alcoholics are somehow uninteresting has kept some of our most talented, innovative people from wanting to work in this field.

Hidden Envy or Compassion?

If we are to treat alcoholics successfully, we must believe that recovery is possible—and that it is desirable. But it seems that clinicians find it especially easy to joke about alcoholism in a way that hints, at least, that they are not really sure they want to do anything about it. Think back, and see whether you can remember times when the alcoholic has been the special butt of jesting in your own conversations. Somehow, it just seems that drunks are especially funny, whether it's a character portrayed by W. C. Fields, a television character, or the patient in the ward. The problem, I think, comes from our tendency to identify an alcoholic's drinking with our own. To us drinking is associated with having a good time, relaxing, and enjoying oneself in general. So a patient whose main complaint is too much drinking seems to be a person who is especially carefree, who is especially devoted to having a good time. The clinician may fail to see the patient's real suffering and may harbor a lurking envy for this carefree fellow who can "do as he pleases." Most psychiatrists and psychologists have a strong orientation to-

ward work and duty or they would never have achieved their professional status. The seemingly hedonistic alcoholic patient may represent an aspect of ourselves that we have repressed in our quest for professional competence, and there may be some unrecognized reluctance to interfere with the "fun" the alcoholic is having. This unacknowledged envy, however, can easily be transformed into dislike: "Why should this guy be able to do as he pleases, when I have to work my head off? Why should I try to help *him*?"

If one looks and listens more carefully, he will find that the alcoholic's drinking is *not* like one's own—that there is a desperate, driven quality about it that completely separates it from moderate drinking for relaxation, pleasure, or sociability. I have noticed this identification with the alcoholic especially in young clinicians—"You may see he's acting in a self-destructive manner, but that's only clear to someone on the outside—he's having a ball!" But the alcoholic is not "having a ball." At some stage in his drinking, perhaps he did. But by the time he presents himself for treatment, or is brought in by someone, he is hurting. Whatever pleasure he may once have felt is now outweighed by the pain, despite the bravado he may assume. Recognizing this pain may help us to see the bravado as a pathetic attempt to maintain some semblance of dignity. Eventually we become capable of a compassionate view of the alcoholic, not one of hidden envy or dislike.

A Flexible Approach

What, then, are the attitudes that are necessary for successful treatment of alcoholics? Our approach must be diversified and flexible, recognizing the vast range of personality organization and types of pathology that may find expression in excessive drinking. We must be pragmatic, adjusting our approach to the realities of the situation, and making the best possible use of all available modalities for helping alcoholics. We must be inquiring and innovative, realizing that

it is an interesting problem, deserving our best efforts. And we must be compassionate—not in a “bleeding heart” or “do-gooder” sense, but in the truest sense of empathy, of feeling with our patients. With these attitudes, and with our fullest utilization of our best clinical skills, alcoholism can be treated, and it must be.

References

Glasscote, R. M., Plaut, T. F. A., Hammersley, D. W., O'Neill, F. J., Chafetz, M. E., and Cumming, E. *The Treatment of Alcoholism: A Study of Programs and Problems*. Washington: Joint Information Service, American Psychiatric Association and National Association for Mental Health, 1967.

Menninger, K. *Man against Himself*. New York: Harcourt, Brace, 1938.

Solomon, R. L., and Wynne, L. C. “Traumatic avoidance learning: the principles of anxiety conservation and partial irreversibility.” *Psychological Review*, 61, 353-395, (1954).

Whitney, E. D. *The Lonely Sickness*. Boston: Beacon Press, 1965.

Mme. le Dr. Curlee, une psychologue membre du personnel de la Veterans' Administration Hospital d'Indianapolis, Indiana, déclare que toute tentative de se rabattre sur une explication unique causative en traitant de patients alcooliques est inévitablement vouée aux erreurs en tentant de les comprendre et de les traiter. Ce qui est demandé, plutôt, est une flexibilité et un respect pour la diversité qui permettent au thérapeute de voir chaque patient tel qu'il est. Les caractéristiques communes de nouveaux patients alcooliques peuvent fort bien, au moins en partie, être le résultat de leur habitude de boire et des conflits que cela crée entre les patients et leur entourage.

Le Dr. Curlee croit que toute façon d'aborder la raison du boire excessif n'est possible qu'après le traitement direct du symptôme lui-même (le boire) et que toute tentative de comprendre ou de soigner l'état pathologique est voué à la défaite aussi longtemps que le patient continue de boire. Il existe plusieurs genres de traitements parmi lesquels choisir, et le choix devrait se faire selon les caractéristiques de chaque patient. Beaucoup dépend aussi de l'attitude des cliniciens. Certains semblent approcher le patient alcoolique avec une attitude hostile ou défaitiste (avec l'envie non avouée pour son hédonisme de la vie). Une meilleure approche est une de compassion, de sympathie, de flexibilité et aussi de pragmatisme.

Cigarette Smoking and Its Effects

By Sherrill Game and Paul Devenyi

Despite the fact that cigarette smokers generally have more illness and shorter lives than non-smokers and that cigarette smoking declined between 1965 and 1970, the Department of National Health and Welfare has estimated that in 1970 approximately 44 per cent of the male and 31 per cent of the female population 15 years and older in Ontario still smoked cigarettes regularly. During the last 20 years, numerous research reports and other reports have been published in Canada, Great Britain, and the United States on the relationship of this common practice to health. One of the most significant of these is the 1971 Report of the U.S. Surgeon General's Advisory Committee on Smoking and Health, which brings together and reviews past and current research findings in this field. The relationships between cigarette smoking and many diseases are discussed in this Report, as well as the effects of smoking during pregnancy. A general account is also given of the various theories as to why cigarette smokers have more illness and higher death rates than non-smokers. Our purpose here is to present highlights from this important review.

Diseases of the Heart and Blood Vessels

Coronary heart disease is the number one killer in Canada, as in the United States. Smokers run a higher risk than non-

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smokers of developing coronary heart disease or of dying from heart attacks. Cigarette smoking¹ can act jointly with certain other factors (e.g., high blood pressure, physical inactivity, high serum cholesterol, and inherited predisposition) to increase risk of coronary heart disease. People with heart conditions who smoke run the risk of accelerating this process. If a person stops smoking, however, he is less likely to die from coronary heart disease than if he did not do so.

Cigarette smoking also affects blood vessels in other parts of the body. Smokers are more likely to die from cerebrovascular disease than non-smokers. (Cerebrovascular disease is a condition in which hardening of the blood vessels in the brain may lead to stroke.) Cigarette smokers also run a higher risk than non-smokers of developing peripheral vascular disease—a condition involving the blood vessels in the extremities. People with peripheral vascular disease who smoke run the risk of increasing its severity.

Respiratory Problems

Shortness of breath, cough, and excessive saliva occur more frequently in smokers than in non-smokers. Smoking also seems to slow down or to stop the work of cilia—small hairs in the respiratory passages which remove dirt by beating rapidly—thus allowing harmful substances to stay in the respiratory system.

Respiratory infections such as chest colds and pneumonia are more common and more severe in smokers—particularly heavy smokers—than in non-smokers. Lung complications (e.g., infections, blood clots) occur more frequently after

¹For most diseases associated with smoking, the relationship is stronger for cigarette smokers than for pipe and cigar smokers. However, all smokers run a higher risk than non-smokers of developing cancer of the larynx, mouth, and esophagus. Pipe smoking is causally related to cancer of the lip.

surgical operations on smokers than after operations on non-smokers. In people suffering from asthma, smoking may increase the frequency and severity of the attacks.

Cigarette smoking is the most important cause of chronic bronchitis, a disease which produces inflammation in the bronchial tubes and slows down air flow to and from the lungs. Emphysema, a condition in which lungs lose their elasticity and retain too much air, occurs more frequently in smokers than in non-smokers. Risk of dying from chronic bronchitis or emphysema is also increased by smoking. Ex-smokers have lower death rates from these respiratory diseases than those who continue to smoke.

Cancer

Cigarette smoking is the main cause of lung cancer in men. It is also a cause of lung cancer in women but accounts for a smaller proportion of the cases than in men. The death rates for women who smoke, although significantly higher than for female non-smokers, are lower than for men who smoke.

The risk of developing lung cancer increases with the number of cigarettes a person smokes per day, the number of years he has smoked, and the earliness of the age at which he started smoking. Smokers who use non-filter cigarettes run a higher risk than smokers who have switched to filter cigarettes. Risk of developing lung cancer diminishes if a person stops smoking; ex-cigarette smokers have much lower death rates from lung cancer than those who continue to smoke.

Smoking is related to cancer in other parts of the body as well. It is an important factor in causation and development of cancer of the larynx and also plays a part in development of cancer of the mouth and esophagus. In addition, an asso-

ciation is suggested between cigarette smoking and cancer of the bladder, kidney, and pancreas.

Other Conditions

Women who smoke during pregnancy tend to have smaller babies and are more likely to give birth prematurely than women who do not smoke during pregnancy. They also have a greater number of stillbirths, and death among their newborns is more common. Male cigarette smokers are more likely to get stomach ulcers than non-smokers; they also have higher death rates from this condition. Smoking appears to slow the healing of ulcers as well.

Mode of Action

As information about hazards of smoking has accumulated, researchers have become interested in *why* cigarette smokers have more illness and higher death rates than non-smokers. The Report discusses a number of theories as to why this happens.

Theory No. 1.

Cigarette smoking starts a disease process and continues to produce progressive, irreversible damage until smoking is stopped. The amount of damage is directly related to the total number of cigarettes smoked over the years. If smoking is stopped, this process also stops (although further deterioration may occur through aging or exposure to other harmful substances). Damage caused by smoking is permanent. This theory could account for the relationships that exist between cigarette smoking and diseases of the blood vessels, chronic bronchitis, and emphysema.

Theory No. 2.

Cigarette smoking starts a disease process, but the body continues to repair itself until some critical point is reached. At

this point, the process is no longer reversible. The amount of damage seems to be directly related to number of cigarettes smoked per day when the critical point is hit, but can also be related to the total number of cigarettes smoked over the years. If smoking is stopped before the critical point is reached, risk of permanent damage is reduced; if smoking is stopped after this point is reached, however, damage is permanent. This theory could account for the relationship that exists between cigarette smoking and lung cancer.

Theory No. 3.

Cigarette smoking promotes disease, either by supporting its development or by impairing the body's ability to cope with and defend against disease. This may take place in one of three ways: cigarette smoking may make an unnoticed condition a readily detectable one; it may turn a mild condition into a more severe one; or it may transform a serious condition into a lethal one. This type of action could account for part of the excess mortality among smokers from a number of diseases (e.g., some respiratory disease and coronary heart disease).

Conclusion

These different theories concerning ways in which cigarette smoking may be related to illness and death are attempts to explain what cigarette smoking can do to the body. It is clear that cigarette smoking presents a serious hazard to health. According to current theory, giving up smoking halts certain disease processes and significantly slows others, but some of the kinds of damage that can be produced by smoking are permanent. In light of this, then, it seems advisable for smokers to stop—and even more advisable for non-smokers not to begin.

Mme Game, une assistante à l'éditorial de la division des communications informatives à l'Addiction Research Foundation de Toronto, et le Dr. Devenyi, directeur des services de santé des employés, à la même place, présentent les points importants du rapport 1971 du Comité consultatif du U.S. Surgeon General sur l'habitude de fumer et la santé. Le rapport entre la cigarette et les ulcères; le cancer des poumons et certains autres organes; les autres maladies du système respiratoire; et les maladies affectant les vaisseaux sanguins du coeur, du cerveau et des extrémités sont analysés tout comme les effets de la cigarette durant la grossesse.

Un compte-rendu est aussi donné d'un nombre de théories courantes à savoir pourquoi ceux qui fument la cigarette sont plus souvent malades et ont un plus haut taux de mortalité que ceux qui ne fument pas. Selon ces théories, l'abandon de la cigarette arrête la marche de certaines maladies et entrave sérieusement la marche d'autres, mais quelques-uns des dommages causés par la cigarette sont permanents.

The Forgotten Children

A paperback book by R. Margaret Cork

This is the second printing of a book about 115 children who were interviewed by Margaret Cork, the social worker who heads the Addiction Research Foundation's Youth Counselling Service in Toronto. All of these children came from the homes of alcoholics, and most of them have disturbing stories to tell. Miss Cork says these children need help. 95 cents.

The Pursuit of Intoxication

A new paperback book by Andrew I. Malcolm

Dr. Malcolm, a staff psychiatrist with the Addiction Research Foundation for eight years, examines the many reasons why people have used and continue to use the psychoactive drugs, under five main headings: Religion, Medicine, Endurance, Extinction, and Recreation. The book not only has something to say about all drugs in current use; it also attempts to place the use of these drugs in historical perspective. \$2.50.

For information about obtaining these books, see page 36.

Drugs, Society, and Personal Choice

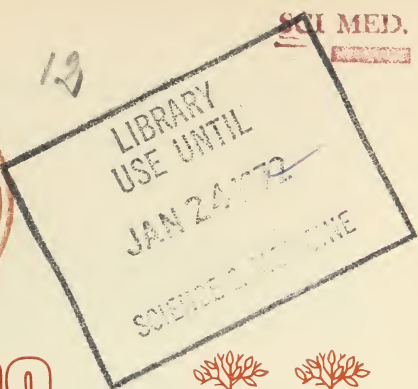
A new paperback book by
Harold Kalant and Oriana Josseu Kalant

This is a book designed to help people—as individuals, as family members, and as policymakers—to arrive at fully informed, balanced, reasonable decisions about drugs. Many scientists today are concerned that their work should contribute to this process. Dr. Harold Kalant is Associate Director of Research and his wife, Dr. Oriana Kalant, is a Research Scientist at the Addiction Research Foundation. They wish to provide through this book data and ways of dealing with data that will assist responsible citizens in achieving a perspective that can lead to an appropriate decision. \$1.95.

The Forgotten Children and **Drugs, Society and Personal Choice** are published by PaperJacks, a division of General Publishing Company, 30 Lesmill Road, Don Mills, Ontario in association with the Addiction Research Foundation of Ontario. **The Pursuit of Intoxication** is published by the Addiction Research Foundation and distributed by PaperJacks. Copies of these books are available at book stores and from General Publishing. They may also be obtained by writing to the Addiction Research Foundation, Communication Programs Division, 33 Russell Street, Toronto 179, Ontario. When ordering any of these books from the Foundation, please enclose with your order \$2.00 for **Drugs, Society and Personal Choice**, \$1.00 for **The Forgotten Children**, or \$2.50 for **The Pursuit of Intoxication**.

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The Great Drug Education Hoax

by Seymour Halleck

This is an article which was printed in 1970 in The Progressive, a magazine published in Madison, Wisconsin. We think that the point of view expressed is one that has much relevance to the Canadian scene, despite some comments that are probably closer to the experience of Americans than of Canadians.

Regardless of differences in the amount of "scare" education and heroin addiction, the numbers of young people involved in drug use, and the nature of underlying social problems, Dr. Halleck's central suggestion is one that we recommend for consideration in Ontario. This is his notion that a better kind of drug education might centre around the ethics of artificial euphoria. Whether or not one agrees with Dr. Halleck on such matters as the enforceability of drug laws or the accuracy of drug surveys, his plea for careful "pleasures vs. hazards" assessment of drugs also seems worthy of consideration.

Editor.

It is now obvious to even the staunchest "law and order" advocates that our law enforcement agencies cannot control the use of illegal drugs. Neither harsh penalties, vigorous police surveillance, nor determined efforts to diminish the flow of drugs into the country have prevented millions of young people from experimenting with pharmaceutical agents alleged to be dangerous. In the light of this inability to control drug usage through legal sanctions, it has become fashionable to turn to "education" as the best method of persuading youth to abstain.

Dr. Halleck is Professor of Psychiatry and Director of Student Psychiatric Services at the University of Wisconsin. This article is reprinted with permission from the author and from *The Progressive*.

The American people have great faith in education. They have set out to educate our young people about drug abuse with a vengeance. Lectures on drugs have become almost a fixture of the high school and college curriculum. Even sparsely populated communities have appointed committees charged with promoting drug education. Such committees usually set up lectures or forums at which young people and their parents can hear experts discuss the effects and relative dangers of a wide variety of pharmaceutical agents.

Strangely enough, repetitive discussion of drugs does not seem to bore most people. Adults turn out for public meetings in amazing numbers. Even students (whose enthusiasm is perhaps buttressed by their being allowed to miss regular class time) become avid listeners and participants. Community leaders responsible for drug education point proudly to the number of lectures and meetings they have sponsored; many seem to feel that as long as they keep talking about the drug problem, it will be solved.

Despite all this enthusiasm, there is still no way of evaluating whether educating young people about drugs has any effect whatsoever in diminishing drug usage. Accurate data about the incidence of drug experimentation are almost impossible to obtain. People who take drugs illicitly are not going to talk about it too openly, and it is also unlikely that they will be honest or cooperative in responding to survey research. It does seem clear, however, from what little survey information we do have, that even with our educational programs, illegal drug usage has continued to increase.

In view of our uncertainty as to the effectiveness of drug education, it seems to me that it would be prudent to consider two disconcerting possibilities. First, that drug education may not discourage youth from experimenting with illegal drugs. Under certain circumstances, as indicated later,

education may even encourage drug usage. Second, that drug education programs may be expensive and ineffective distractions which diminish our motivations to examine basic moral and political questions which may be the very roots of the drug problem.

The Scare Technique

The most prevalent but least effective theme in the drug education program is to "scare the hell out of them." Too often the program consists of one or more meetings at which a local physician, a law enforcement officer, and perhaps a former addict will endlessly catalogue the horrible outcome of drug usage. The physician will exaggerate the degree to which drugs can produce bodily damage. The law enforcement officer will gravely talk about the increasing flow of drugs into the community and will throw in a few anecdotes about young people he has seen ruined by drugs. Sometimes he will even bring in displays of confiscated drugs to show to his presumably horrified audience. The former addict, who is usually the star performer, will recount his sordid experiences as a drug user and will glowingly report the salutary effects of his reformation. It is an interesting show which has much of the flavor of an old-fashioned revival meeting.

Unfortunately, such a biased approach to the drug problem is unlikely to have a positive influence upon young people. The kids know better. A sizeable proportion of high school and college students in the audience have already experimented with marihuana. Many have found this experience to be a pleasant one. Few marihuana users believe that they have been harmed by using the drug. When these young people hear speakers describe marihuana as a narcotic which belongs in the same class as harder drugs, they are understandably skeptical of the speaker's reliability. Since the young person's own experience leads him to believe that the

speaker is exaggerating the dangers of marihuana, he wonders if the speaker is not exaggerating the dangers of other drugs as well.

It is also true that those students who have never used illegal drugs usually know somebody who has. Generally the student who does not use drugs hears only favorable reports of their effects from those who do. The non-user also notes that most of his user friends do not seem to be suffering the horrible effects described by the speakers. He is much more likely to be influenced by the opinions of his peers than the opinions of adult speakers.

Even the presence of a youthful former addict on the program does not have much deterrent effect on the audience. Usually the former addict has been addicted to heroin. He is likely to have grown up in an urban ghetto community and his life experiences are unlikely to have been similar to those of most of his audience. The young person in the audience who, as a rule, has never experimented with "hard" drugs has difficulty in identifying with the outlook or experiences of a true addict.

Finally, young people do a great deal of reading about drugs. From my own experience in working with student groups, I am regularly impressed with their knowledge of both the scientific and popular drug literature. Unfortunately, many of the doctors and police officers who participate in the "scare the hell out of them" programs have had neither the motivation nor the time to familiarize themselves with the literature.

Usually, when given a chance to ask questions, the young people in the audience find it easy to embarrass a speaker by quoting studies which contradict the speaker's claims. Nor is it difficult for them to expose the moralistic rather than

the factual basis of a speaker's admonitions. Once a speaker's biases and ignorance have been exposed, the younger people in the audience seem to give up. They may continue to confront the speaker but as the meeting goes on it is evident that some are snickering, that others are giving one another knowing glances, and that most are responding to the meeting with an attitude of supercilious resignation.

More Sophisticated Approaches

As educators become more sophisticated they tend to add participants to their programs who provide more factual knowledge about drugs. Some groups will even allow advocates of more liberal drug usage to participate in the education process. Not infrequently, a knowledgeable pharmacologist or psychiatrist will be allowed to present accurate information concerning the physical and psychological effects of drug usage. Young people seem to have an insatiable demand for such information. They will listen avidly as the lecturer discusses chemical formulas, describes sophisticated scientific studies, and lists esoteric side effects of a wide variety of little known as well as popular drugs.

As one listens to such talks, he finds it hard to keep from wondering why sixteen or seventeen year olds should be so fascinated with pharmacology or psychiatry. It is, after all, hardly essential that teenagers have vast knowledge of the physical and psychological effects of psilocybin, LSD, or DMT. It seems quite unlikely that such extensive knowledge is going to help them make a moral decision on whether they will ingest, inhale, or inject an illegal substance into their bodies. One possible, but ominous, explanation of the young people's interest might be that they are already heavily involved in using drugs; that they are simply trying to get as much information as they can so that they can enjoy the most pleasurable drug experience and be informed on how they might deal with any undesirable reactions.

As the young person listens to factual material about drugs, he comes to appreciate that they are not nearly so dangerous as people generally believe them to be. This is particularly true in the case of marihuana. I have had the experience of lecturing groups about the physical and psychological effects of marihuana and have noted that as long as I present only objective material, and do not raise moral questions, the audience seems to become progressively more enthusiastic about the drug. At least in some instances the factual approach to drug education could encourage rather than discourage experimentation.

The Pied Pipers

If an education program also includes an advocate of drug experimentation, the program is even more likely to have unintended effects. There are many people in our society, including some professionals, who feel that consciousness-altering drugs can produce pleasant, enlightening, and even spiritual experiences. They view some of the drugs, particularly the psychedelics, as agents that may eventually have a highly beneficial influence on man's well-being. Not infrequently, these individuals are charming or charismatic. Drugs are their "thing" and they are likely to know a little more about them than the other speakers.

In the eyes of the youthful audience, these drug advocates are also likely to be people who share the values of the "now" generation and who are quite adept at communicating with the young. In any debate with biased or even cautious advocates of drug control, they are quite likely to exert the greater influence. I have watched scholarly and articulate men debate with some of the "Pied Pipers" of the psychedelic era such as Timothy Leary, and have noted that even if the scholar presents the more telling arguments, he usually loses his audience.

We must also consider the possibility that repeated exposure to any subject may markedly alter our attitudes toward that subject. As illegal drugs are endlessly discussed and rediscussed they become more familiar and perhaps more acceptable to us.

Provocative Reporting

It is conceivable that the plethora of publicity about drug usage, and the abundance of educational meetings held, simply neutralize the negative feelings with which adults view drugs and arouse the curiosity of youth who are prone to experiment and take risks anyway. The problem is compounded by the tendency of the news media to report the proceedings of a drug information program in a provocative manner. The drugs may be described as dangerous but they are also described in a manner that lends them an aura of mystery and excitement. The young person may be thus stimulated to indulge in behavior that not only appears to be "the thing to do" but which also promises to be adventurous.

A Help for Parents and Professionals

Though I have questioned the value of drug education programs in general, I do not mean to suggest that educational programs must, of necessity, be useless or dangerous. They can certainly be helpful to adults. When it comes to holding dialogues with teenage children about the potential dangers of drugs, the average American parent is totally outmatched. For reasons mentioned earlier, his child is likely to have a fund of information and a grasp of the issues which exceeds his own. At the very least, parents who decide to counsel their children about the use of drugs should start out with a knowledge of the facts. It is also important that professionals know about drugs; the family physician, the high school counsellor, the teacher, and the minister quite frequently seem to

be as ignorant of the uses and effects of drugs as the ordinary adult.

Social and Ethical Issues

Educational programs might be helpful to young and old alike if they focused on broader social and ethical issues. It would be useful to begin by acknowledging that the abuse of legal drugs, including those prescribed by physicians, is probably a greater problem for our society than abuse of illegal drugs. And abuse of alcohol still creates more mental and physical suffering among our citizens than abuse of other legal drugs.

Safety and Morality

If the drug problem is viewed from a broad perspective, a crucial ethical question for our society is: Which drugs, legal or illegal, are worth using? Which drugs, if any, make life better? Most drugs provide the user with a pleasant experience—for the moment. Conceivably, there may also be drugs which could expand human awareness and provide people with new insights. Whether one uses tobacco, alcohol, marijuana, amphetamines, or heroin, he is searching for something, occasionally for greater awareness but usually for stimulation or relaxation, for a temporary respite from the tedium or stresses of everyday life. If we agree that man is entitled to a certain degree of artificial stimulation or relaxation, it is important to know which drugs do this most effectively and with the greatest safety.

The issue of safety must be considered in basic, honest terms. To begin with, the educator must acknowledge that there is no drug known to mankind that is not dangerous if used to excess. Many of the arguments between generations as to whether the older generation's drug, alcohol, is preferable to

the younger generation's drug, marihuana, arise out of the protagonists' failure to define what kind of dosages they are talking about. If one compares the effects of large dosages of alcohol against the effects of small dosages of marihuana, alcohol is obviously the more dangerous drug. However, when purer forms of marihuana are used frequently, marihuana may have as many undesirable side effects as alcohol. Both drugs can also lead to social deterioration.

On the other hand, both drugs can provide man with great pleasure. Society's task is to consider the physical, psychological, and social dangers of each drug and to make moral decisions as to whether the pleasures produced by that drug are worth risking its hazards. Similar kinds of questions are relevant to the use of other drugs such as tobacco, LSD, barbiturates, or the amphetamines. The search for answers to these basic questions could provide a more rational basis for future legislation than the puritanical or evangelistic approaches prevalent now.

Young people as well as their parents could benefit from a careful consideration of the morality of searching for artificial stimulation or tranquillity. There has probably never been a society which has not used some kind of fermented beverage or botanical product to make the pains and outrages of everyday life more tolerable. It would seem that man's existence is so plagued by anxiety, uncertainty, and loneliness that he regularly seeks temporary states of artificial escape. The problem here is that a certain degree of stimulation or tranquillity obviously benefits many people, but too much alteration of consciousness does not bring out the best in man. People need a certain amount of anxiety and frustration to be creative, to make decisions, and even to confront oppressive institutions within our society. If they become too euphoric or too tranquil, they do nothing.

I have noted over several years of watching protests at the University of Wisconsin that activism and drug usage seem to be inversely related. I am not saying that protesters do not use drugs. They frequently do, and for that matter the drug experience may even encourage them to question existing values even more vigorously. What I am saying is that at a time of confrontation, when it is urgent to bring about useful change, a ready availability of drugs in the community seems to diminish the drive to seek change. I have seen dedicated activists become so involved in drug usage that they lost their desire to continue their activism. In their narcotized, peaceful states, such youth may be more tolerable to the "establishment," but their use of drugs has rendered them ineffective as agents of social change.

Even in smaller social relationships, excessive drug usage seems to have a pernicious effect in maintaining an undesirable status quo. I recently counselled a couple who had serious problems with each other. They had many disagreements, different tastes, and, like many other married couples, had devised subtle but elaborate means of keeping each other unhappy. Periodically they would get into an argument and try to consider their differences seriously. They both, however, happened to be heavy marijuana users. Whenever they felt too anxious about their relationship, they would simply "turn on" and their problems would never be resolved. They remained tranquil, but both were chronically depressed over a relationship which would have been made meaningful if they had really confronted each other. Similar kinds of oppressive status quos are probably being maintained in many marital and other social relationships whenever drugs (legal or illegal) are used to narcotize individuals who have problems but who are reluctant to deal with them.

Young people do seem to understand that if the world were peaceful and that if all men were free, drug usage might be

a luxury we could easily afford. They can also appreciate that in a world in which there are so many oppressive forces to be dealt with, in which there are so many things that need doing and changing, and in which the joys of creativity still represent one of the most profound of human experiences, excessive search for artificial euphoria might be socially dangerous. I do not know if raising ethical questions about the general problems of artificial euphoria actually discourages young people from using drugs. Certainly such an approach cannot provide any young person with a clear yes-or-no answer on whether he should experiment with a particular drug. It does, however, provide him with an intellectual framework from which he can make a rational decision unbiased by the exaggerated views of his peers or his parents. And considering the problem of drug usage in basic moral or ethical—and social—terms does seem to minimize the destructive and inane polarization of viewpoints which appears to be an inevitable result of the ordinary drug education program.

Obviously the approach I am advocating would lead to serious questioning of existing laws governing drug usage and distribution. Many of our laws are based on unrealistic fears and misinformation. If we approached the drug problem by recognizing man's need to seek relief and release from a world he never made, by being realistic as to the physical and psychological dangers of drugs, and by considering the extent to which society has the right to control the use of agents that interfere with social progress, we could at least develop a rational basis for recommending legal reform.

With the exception of a few esoteric drugs—which are not used too frequently anyway—most of the drugs which youth currently use have been with us for a long time. Why should young people suddenly turn to drugs now? It is unlikely that youth's innate need for artificial escape has changed. Rather,

something about the society must have changed. Many social factors can be invoked to explain the drug problem. There is the generation gap, and the increasing tendency of youth to imitate peers and to derive their values from peers. There is our growing permissiveness and our willingness to tolerate new kinds of social experimentation. There is our tendency to search for meaning in an era in which past values are losing their relevance. And most of all, there is despair.

Perhaps the best explanation for the growing use of drugs in this country is that we are an unhappy society. It makes little difference whether one is talking about young people who use illegal drugs or older people who use legal drugs. In our frustration, our anxiety, our fear, our boredom, and our purposelessness, we all use too many drugs. Our affluence and leisure do not bring us happiness. Our failure to deal with urgent problems such as the rapid rate of technological change, over-population, pollution, or the war in Vietnam leaves us feeling frustrated and impotent. The younger generation seems especially desperate. They fear the future, distrust the past as a guide to the future, and are relentlessly trying to live in the moment. The drug experience heightens their sense of the present and enables them to avoid the painful realities of their lives.

It is my belief that the drug problem is only a symptom of a sickness that pervades our entire society. Drug education can be thought of as a treatment that is designed to treat the symptom without doing anything about the causes of the illness. Whether it is an effective treatment is far from proven. But even more distressing, by relying upon education as a symptomatic treatment, we are lured away from the real problems which are causing the symptom. Drug education programs can be helpful. But unless supported by a firm commitment to examine and deal with the more basic causes of human despair, they are nothing but a "cop-out."

*LA GRANDE
CONFUSION DE
L'EDUCATION
SUR LA
DROGUE*

Le Dr. Halleck est professeur de psychiatrie à l'Université du Wisconsin et directeur des services psychiatriques des étudiants à ce même endroit. Dans cet article, il met en contraste les programmes éducatifs sur la drogue qui sont basés sur des techniques d'apeurement comparativement à d'autres genres de programmes plus sophistiqués, et fait le point sur certains problèmes particuliers à chaque genre. Il suggère une approche quelque peu différente—une basé sur la formulation de questions morales de base. Il suggère aussi que le problème de la drogue est un symptôme d'une maladie qui affecte la société entière. L'éducation sur la drogue, dit-il, doit être appuyée par un engagement formel à étudier et à faire face aux causes plus fondamentales du désespoir humain plutôt qu'avec un seul de ses symptômes.

Viral Hepatitis and the Drug Culture

by Murray M. Fisher

Over the past few years there has been an increase in the incidence of viral hepatitis. This increase has been due largely to the spread of viral hepatitis among young people in the drug culture. In fact, the abuse of drugs has become the major determinant of the pattern of viral hepatitis in North America. People who admit using illicit drugs by needle now account for about 30% of all adult viral hepatitis hospitalizations in major North American cities, and about 50% of those viral hepatitis patients who deny such use of illicit drugs have had intimate contact with persons who do use them. Therefore, the drug culture has aggravated considerably the general problem of viral hepatitis.

It seems unlikely that dissemination of information about the dangers of hepatitis can have much effect on the behavior of confirmed drug takers. However, it does seem important to warn casual abusers, experimenters, and non-users who are considering experimentation. It is therefore the purpose of this paper to provide information that may help teachers, social workers, and other professionals—as well as parents—to communicate effectively on the subject with many young people.

Types of Hepatitis

Hepatitis is an acute inflammation of the liver. Viral hepatitis, strictly speaking, involves an inflammation of the liver

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caused by a virus. However, in practice, the term is usually reserved for certain conditions which are in fact generalized diseases and which may not be caused by viruses. In spite of decades of intensive investigation, the causal agents for these very common diseases have defied isolation. While there is no doubt that these agents are highly infectious, the proof that they are viruses is still lacking. Because the causal agents have not been isolated, there are still no absolutely diagnostic tests for these diseases, our knowledge of their natural history has remained incomplete, and no specific treatment for them has become available. The diseases commonly referred to as viral hepatitis are therefore one of the monumental frustrations of modern medicine. They are diseases of worldwide distribution, of major social and economic importance, and of increasing frequency for which there are no known causes and no specific treatment.

There are two main types of viral hepatitis: enteric hepatitis and serum hepatitis. *Enteric hepatitis* is the predominant form of the disease in our society. It occurs sporadically and in epidemics which are usually traceable to contaminated food or water. It is most prevalent in autumn and winter. It has its highest attack rates but lowest virulence among children and young adults. It is considered to have an incubation period of 15-60 days and to be spread by the oral-fecal route. However, it can also be spread parenterally—that is, through breaks, made either by needles or by cuts or abrasions, in tissue membranes (primarily the skin, the mouth, and the genito-urinary tract). This type of spread may well be an important source of post-transfusion hepatitis, 45-70% of which has an incubation period of less than 60 days.

Serum hepatitis has a longer incubation period (60-180 days) and is most often spread by the parenteral route. A very small fraction of a drop of infectious serum can transmit the disease. With this degree of contagiousness, the disease can

easily be transmitted through sexual intercourse, oral-oral contact, and even the sharing of toothbrushes, razors and nail-files, let alone of syringes and needles. Medical and dental injections and the transfusion of blood and its products provide many causative situations. Tattooing, ear-piercing, and other non-medical surgery also provide hazards. There is a higher risk of serum hepatitis among medical and paramedical personnel and especially among those involved in artificial kidney and organ transplant units. But by far the largest reservoir of this type of hepatitis is in the drug culture. For some time it was thought that serum hepatitis was transmitted only by the parenteral route. It is now clear, however, that serum hepatitis can also be spread by the oral-fecal route. Although the contribution of this type of spread to the total number of cases in a given geographical area is not yet known, it seems to be important to the spread of viral hepatitis within and beyond the drug culture.

What is it like to have Viral Hepatitis?

Acute viral hepatitis usually begins with an illness whose symptoms include general malaise, abdominal discomfort, nausea, vomiting, change in bowel habits, and aversion to food and tobacco. Muscular aches and pains, depression, rashes, and fever are also not uncommon. This stage can last up to 10 days.

The *icteric (jaundiced) stage* then appears. It is characterized by dark brown urine, pale stools, and obvious jaundice. Most of the symptoms of the first stage usually subside within a few days of the onset of jaundice; and within 10 days of its appearance, the jaundice itself begins to clear. Although the *convalescent stage* usually lasts only two to three weeks, it may take six months or more for full recovery. During this time, it is important to remain under medical supervision because one can feel well even in the presence of continuing

liver damage. About 15% of patients who have had acute hepatitis with jaundice will have relapses during the convalescent stage. The deterioration may show only in certain biochemical tests of liver function, or there may be a return of some of the symptoms and signs which characterized the initial illness. But these relapses are usually much less severe than the original illness, and recovery is usually complete.

In rare instances, acute viral hepatitis is fatal. Liver cell failure appears within eight weeks of the onset of illness and the patient develops mental confusion which goes on to coma, bleeding disorders, fluid retention, and other marked disturbances in body chemistry. Death occurs frequently in such cases; only 20% of those patients who go into a deep coma survive.

After Acute Hepatitis

The prognosis is excellent for the vast majority of patients with viral hepatitis, enteric or serum. Most patients recover completely. Nevertheless, there is little question now that some patients do go on to develop *cirrhosis*, a disease in which the structure of the liver is permanently disorganized by the scars which form after certain types of liver injury. Because of the absence of specific diagnostic tests for viral hepatitis, the incidence of this kind of progression is not known; but it is thought to be extremely rare. The same difficulty applies to attempts to estimate the incidence of *chronic hepatitis*, a condition involving inflammation of the liver for more than one year after an attack of acute hepatitis. Not uncommonly, the patient recovering from viral hepatitis experiences a prolonged period of anxiety, depression, and general malaise for which no physical basis can be found. The patient with this problem, the so-called *post-hepatic*

syndrome, can be reassured that he will in time return to normal. But the return can take months and it can demand a great deal of supportive care.

Anicteric Hepatitis

Although adequate statistics are not yet available, it appears that liver involvement sufficient to produce jaundice is a relatively infrequent development in the course of viral hepatitis. This means that a very mild and subtle form of hepatitis is the most common form of the disease and that there are probably thousands of cases of viral hepatitis each year that are never diagnosed as such or indeed even seen by physicians. People with this form of the disease are said to have *anicteric* hepatitis, the term simply referring to the fact that they do not develop jaundice. Although their condition is probably not serious per se, these persons form an important group from the medical point of view because some of them may progress to chronic hepatitis, may become carriers of hepatitis capable of transmitting the disease to others, or may go on to cirrhosis. If they do so, and how often they do so, will remain as controversial problems until specific tests for viral hepatitis become available.

Trends in the Treatment of Viral Hepatitis

Currently it is believed that as little treatment as possible should be given. The patient should be kept out of hospital if his home situation and his condition permit. Isolation is not necessary, although the patient and the people attending him should pay strict attention to handwashing and the disposal of excreta. There is probably a limit to the degree to which even these precautions need to be carried out, since the most infectious period of the disease is that which precedes the development of jaundice.

The patient should find his own level of activity. He should avoid undue fatigue but be allowed up when he wants to get up. Mild exercise as tolerated is recommended, and convalescence should not be prolonged. In fact, the patient should return to work or school when he feels up to it.

The patient should eat what he wants to eat of a normal, well-balanced, attractive diet; vitamin supplements are not necessary if he is able to take adequate amounts of such a diet. An occasional drink of alcohol during convalescence will do no harm, and the still practised restriction of "a year off alcohol" is not justified. In most cases drugs are best avoided in the treatment of viral hepatitis, and obviously the use of illicit drugs or other self-prescribed drugs must be forbidden. The liver which must process such drugs needs a rest from tasks of this kind.

What patients recovering from acute viral hepatitis need most is a tremendous amount of moral support. This can usually be given with confidence. If ordinary enteric viral hepatitis can go on to cirrhosis, it does so extremely rarely. Serum hepatitis, on the other hand, *can* go on to cirrhosis, but the vast majority of cases do not. In any event, doctors like to watch these patients carefully and to evaluate their liver function regularly. The development of certain complications are indications to the doctor that the patient needs hospitalization or at least further investigation.

Household and other intimate contacts of patients with enteric hepatitis should be given gamma globulin during the incubation period of the disease—that is, as soon as possible after diagnosis of the primary case. Gamma globulin does not help the patient once this disease has developed to the point of presenting signs and symptoms, and it does not appear to help at any point in serum hepatitis.

Future Prospects

Although viral hepatitis continues to present a tremendous challenge to medicine, the prospects for substantial progress in the immediate future are very real. It is clear now that a particle found in the blood and other tissues of patients with certain types of hepatitis, and known as the Australia antigen, has a very strong association with serum hepatitis. It is also clear that it, or an agent with which it is intimately associated, can cause hepatitis in man. Testing for the Australia antigen of blood used for transfusion is rapidly becoming a routine procedure and it can be expected to reduce significantly the incidence of post-transfusion serum hepatitis. As the use of better analytical methods becomes more widespread, the study of the Australia antigen will continue to make substantial contributions to our understanding of this disease. But there is a great need for more research in this area.

The prospects are also very real for the development of a vaccine—that is, of a safe and effective form of active immunization against viral hepatitis. There is real hope, therefore, that viral hepatitis will one day take its place alongside such well controlled infectious diseases as poliomyelitis and smallpox.

However, even if the vaccine were developed tomorrow—and it is certainly not going to be—the effective control of this disease would still be five to ten years away. For years, therefore, this disease will continue to plague us. Many thousands of people will be made acutely ill, many will suffer permanent damage to their health, and some will die. And all this from a disease which is essentially preventable. We must, then, address ourselves as a society to the preventative aspects of this disease and to the encouragement of research in the area. In light of current economic realities and national

priorities, our chief hope for the present would seem to lie in the area of public education. The public must be educated concerning the hazards of viral hepatitis in the use of illicit drugs, in surgery medical and non-medical, and in enthusiastic but dangerous returns to primitive hygiene.

*L'HEPATITE
A VIRUS
ET L'USAGE
DE LA
DROGUE*

Le Dr. Fisher, un membre de la Faculté de médecine de l'université de Toronto est un clinicien et un chercheur dans le domaine du foie et de ses maladies. Dans cet article, il fait remarquer qu'il y a eu une augmentation, au cours des dernières années, des cas d'hépatite à virus. Cela est dû, en grande partie, à la propagation de la maladie chez les jeunes gens adonnés à la drogue.

Le Dr. Fisher décrit les caractéristiques de différents genres d'hépatite et expose à grands traits les différents stages par lesquels une personne atteinte d'hépatite à virus aiguë aura à passer. Il discutera aussi des tendances actuelles de traitement de la maladie et des recherches connexes. En terminant, il indique que l'hépatite à virus est essentiellement une maladie qui peut être empêchée mais au sujet de laquelle existe un grand besoin d'éducation publique.

Poem

by George Swede

I am a man	in front of others
who has learned	naked
to communicate	in front of me
sympathetic	I can communicate
honest	I have been
aware	open
I have undergone	to everyone
sensitivity training	let them
revealed	touch me
my authentic self	my heart
in T-groups	my skin
awakened my senses	every limb
in touch, taste and	and orifice
smell groups	I can make children
shed my inhibitions	laugh
grabbed for intimacy	I can make cats
in nude marathons	purr
realized my potential	I can interact
in many different	establish contact
encounter groups	yes
I have shown	I can communicate
trust	but
verbal and non-verbal	why don't I
naked	

Mr. Swede teaches psychology at the Ryerson Polytechnical Institute in Toronto. This poem is reprinted with kind permission from the author and from *The Ontario Psychologist*, the journal in which it first appeared.

Human Problems and Chemical Solutions

by Charles H. Aharan

Traditionally man has turned to chemicals to treat his illnesses, to reduce his pains, to escape the clutch of reality, and to achieve transcendence. When surveying the drug scene, many will say that man has relied on chemicals since before the dawn of recorded history, and therefore that this reliance must be accepted as a part of the human scene. If this is so, it raises the question, "Is there anything really different about our current drug taking behavior, and is there a valid reason for our growing concern?" For various reasons, I believe the answer to these two questions to be "Yes."

It is highly probable that we are using drugs for the same reasons that they have always been used, but it is also probable that we are in an age in which various pressures are creating intensely painful problems for a much greater number of individuals. It is also likely that there is a much greater acceptance of, and belief in, the efficacy of chemical solutions to human problems. Finally, and perhaps most important, the number of chemicals has increased tremendously, as has their availability and the awareness on the part of the general population of their nature and effects. It will be the purpose of this paper to outline a few of the factors which may contribute to drug abuse in our society.

How Responsible are We?

The great success of medicine in utilizing drugs in the fight against disease has done much to condition us to the idea of

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solving human problems through drugs. This fact, when combined with the tendency to include a much wider range of human problems under the heading of "illness" than ever before, has greatly extended the number of difficulties for which it has become appropriate to seek chemical solutions. The move toward inclusion of various forms of behavior under the rubric "sickness" is most dramatically revealed in the area of mental illness. In recent years we have witnessed attempts to convince the general public that mental illness is an illness like any other. I do not object to efforts to obtain for the mentally ill more humane and considerate attention by reducing stigma. However, the effort to convince the public that all mental illness is the same as any other form of illness has had, and is having, far-reaching consequences. Much of what falls into the category of mental illness is, in fact, a maladaptive approach to life. Considering mental illness as being similar to physical illness has therefore led many people to the conclusion that many problems in living are the result of illness, and, by implication, beyond the individual's ability to control. I fear that the importance of human responsibility is often compromised by too great a readiness to apply to deviant forms of behavior the label of illness which, in our society, tends to relieve the individual of his accountability.

Because of its great success in the use of chemicals to combat man's physical ills, it is natural that medicine should conclude that what works for the body will work for the mind. In some instances I am sure this may be appropriate and work well; but in many cases it not only does not work but is downright damaging. One example of the problem may be found in the role of pain reduction. In a physical illness, making the patient comfortable by reducing his pain is a valid procedure. It often seems to be almost as important as curing the illness. Undoubtedly, this procedure is humane, and it probably facilitates recovery. (It is highly probable

that physical pain serves no useful purpose beyond identifying the fact that something is wrong.) Health is frequently defined as the absence of illness. Certainly, at least from the patient's point of view, well-being is synonymous with the absence of discomfort.

In the area of "emotional illness," however, can we say that well-being or even health is characterized by the absence of pain? Is it not far more likely that emotional stability is characterized by the ability to cope in the presence of pain? *This would mean that the goal of treatment for emotionally disturbed people should not be making them comfortable or reducing their pain, but encouraging them to utilize their own resources to face the realities of their lives.* Emotional health, whatever else it may be, is the feeling within the individual that he can meet and cope with whatever it is that life presents.

Maintaining a State of Comfort

However, treatment of the emotionally disturbed which is based on the narrow medical model is inclined to pay much more attention to the patient's comfort and to aim at immediately reducing his discomfort. As a result, we have now arrived at the point where there are pills to put a person to sleep, pills to give him energy and keep him awake, pills to calm him down and to reduce his anxiety. We have almost reached the point where any desired mood can be achieved, at least to some degree, by the taking of a pill. The point to remember is that these preparations do not cure anything—they simply alter the way the individual feels. I do not wish to imply that these remedies do not have a valid role in the treatment of seriously disturbed people or that they cannot play a valuable part, on a short-term basis, in helping a person to carry on necessary functions, such as earning a living, while adjusting to a profound shock such as sudden bereave-

ment. The fact remains, however, that these tablets and capsules are prescribed by the hundreds of millions annually—which suggests either that there are a staggering number of seriously disturbed or deeply troubled people, or that some of these drugs are being requested and supplied for frivolous reasons.

The widespread acceptance of the use of mood changing drugs is compatible with the high value that society places on achieving and maintaining a state of comfort. Man's tendency to seek expedient, painless solutions to the problems of living is constantly and very effectively exploited. We are urged to believe that we may suffer more from pain than our neighbor, thus justifying our use of stronger pills. Through modern advertising, more and more of the minor annoyances of life are being identified as real problems. We are encouraged to think, for example, that dandruff, bad breath, body odor, and dishpan hands have vast potential for social damage. In a very real sense, it would seem that modern advertising has to create problems in order to sell the solutions. Many of the ads in medical journals seem to imply that normal, everyday role requirements of life cause more pain than one should have to endure. We are encouraged to believe we are suffering unduly and, consequently, that we are entitled to the immediate long-lasting relief that is so readily available. There is, in my opinion, a wide and still growing acceptance of the idea that life cannot be lived without the comfort of drugs. If we are not already in the brave new world we are, at least, on the threshold. It especially concerns me that our movement in this direction is a gradual drift rather than the result of a conscious decision.

In order to evaluate properly the role of drugs in a chemical age, we must ultimately consider questions such as, "What is good for man?" Is it a good thing to rely on chemicals to determine our mood? Is it a good thing to live in a drug-

induced state of comfort? Is it a good thing to relinquish responsibility for the development of our own internal resources?

A Crisis in Character and Values

I would like now to turn briefly to another area which, while not directly related to drug use, does have great relevance. I believe that many of the human problems of our age and culture may be usefully described as "crises in character." Having introduced the concept "character," let me digress and offer a few ideas about the role of "character" in personality. In recent years it has not been fashionable to use this old-fashioned concept when discussing personality theory or the problems of human adjustment. I am of the opinion, however, that this concept is vital to any discussion of human behavior and individual fulfillment.

Character, as I use the term, means a system of belief and the will (motivation) to act in accordance with the belief system. The importance of character is that it provides the individual with a sense of identity. Let me illustrate by posing this question: Is it possible for us to know who we are, to feel a sense of purpose and direction in our lives, in the absence of a system of belief?

The greatest anguish and horror that we can experience is a growing sense of non-being or disintegration of the self. It is the role of the character to maintain our sense of selfhood. Hence, it plays a major integrating role in our personalities. I believe that to be truly human, we must constantly seek to strengthen and direct our character and to recognize that we are responsible for being the kind of persons we are, even when the circumstances of life seem difficult.

We are living through a period of enormous change, the full scope and significance of which we are probably not capable of comprehending. A significant feature of change is confusion in the area of values. We are in an era when many of our cherished and comforting beliefs appear to have been undermined, or at least seem to have been rendered inappropriate to the times. The ferment is apparent in all our institutions. Even those bastions of certainty, the churches, no longer seem to be as secure as they once were and, therefore, no longer offer the comfort they once did. Conditions such as these inevitably produce a "crisis in character." How can we, as individuals, develop and maintain a meaningful system of belief in the face of so much uncertainty? How can we avoid having a feeling of estrangement, a loss of identity?

I cannot pretend to offer a blanket answer, appropriate for all individuals, to this very difficult question. I can only suggest that attempting to escape through drug use, whether our drug is alcohol, or tranquillizers, or barbiturates, or marihuana, or heroin, will be pointless. Facing problems directly, seeking enduring values, is more difficult. I believe, however, that it is ultimately more rewarding.

*PROBLEMES
HUMAINS
ET SOLUTIONS
CHIMIQUES*

Le Dr. Aharan, un psychologue, discute du rôle de la drogue dans la société, avec emphase sur la partie que jouent ces produits chimiques sur le côté émotif par opposition au côté physique de la maladie. Il maintient que le but du traitement de personnes souffrant de troubles émotifs ne devrait pas être de les rendre confortables, mais bien de les encourager à utiliser leurs propres ressources pour faire face à la réalité. Il croit que le vieux concept de "caractère" est encore important en ce qu'il dénote un système de croyance et volonté qui donne à notre vie une raison et

un sens. Le Dr. Aharan dit que nous devons constamment rechercher à renforcer le caractère et à prendre responsabilité pour le genre d'humains que nous sommes, même durant une ère de confusion et de changements rapides comme la présente.

Bon Accord Antiques

Bon Accord Farm, situated on 200 acres of rolling farmland, is a pilot project of the Addiction Research Foundation. It is a rehabilitation community for men with problems related to alcohol. The work program, an important aspect of the project, has included operating an antique shop; repairing, refinishing, and upholstering antique furniture; and manufacturing early Canadian pine reproductions.

Although the antique shop is closed for the winter and will not be re-opening until April, 1972, restoration and repair services are still available at the Farm. Antique furniture and reproductions are on sale in Toronto at the headquarters of the Addiction Research Foundation, 33 Russell Street.

Bon Accord Farm is located at R.R. #1, Elora, Ontario. For further information call the Farm at 519-846-5388 or Mr. Clive Bourke in Toronto at 595-6091.

Phencyclidine (PCP): A Street Drug in the Laboratory

by Joan Marshman and Lois Adair

Between February and October, 1971, fifty of the samples of illicit "street" drugs brought for analysis to the Addiction Research Foundation were found to contain a drug called phencyclidine or PCP. (In the drug culture, PCP has also been known as "the peace pill.")¹ Although phencyclidine is sometimes classified as an hallucinogen along with such other drugs as LSD and mescaline, the samples containing it had not, in general, been sold on the street as phencyclidine. Most frequently, PCP was found in substances sold as mescaline. It was also identified in substances sold as THC (tetrahydrocannabinol), MDA, or methamphetamine (speed). On one occasion, PCP was apparently sold as a mixture of heroin and speed, and on another as harmaline. In one instance, PCP was found in a marihuana cigarette; this combination is popularly referred to in some places as "angel dust." In nearly half of the 50 samples, PCP alone was found. In the remainder, another drug was found as well. Often the other drug was LSD. Speed and MDA were also found.

The 50 samples we have just described made up approximately 20 per cent of the total number brought to the laboratory during the period referred to. This fact should *not*,

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¹ The chemical name for this drug is 1-(1-phenylcyclohexyl) piperidine hydrochloride. It is also known as Sernyl, Sernylan, and CI-395.

however, be taken to mean that phencyclidine was present to this extent among illicit drugs sold on the street at about the same time. The fact that a particular drug is brought for analysis often means that it has caused an adverse or unexpected reaction; therefore, there is an inherent bias toward certain products, rather than others, in what is brought in. However, it is clear that phencyclidine has been present to some extent on the Ontario drug scene during recent months, and there is no reason to suppose that it has disappeared. Therefore, a brief account of some of its characteristic effects and possible hazards will be of interest to professionals who deal with young people who are users or experimenters.

What is PCP?

PCP is a white powder made up of crystals that are soluble either in water or in alcohol. The samples of it that reached the A.R.F. laboratory, however, were in the form of tablets and capsules of many sizes, shapes, and colors. Although PCP was at one time tested in clinical trials as a mood-elevator and as an anesthetic, its legitimate use is now restricted to some aspects of veterinary medicine. It is a drug that is hard to classify accurately because it has different kinds of effects at different dosages. Depending on the amount taken, the time elapsed, and other factors, these effects may, in certain ways, resemble those of a minor tranquillizer or a sedative or an analgesic (pain killer) or an anesthetic or a stimulant. Reactions as different as stupor and high excitement have been observed in experimental studies. Some people who have taken the drug intravenously have experienced illusions and/or hallucinations.² Some who have taken

² A person having an *illusion* perceives stimuli from the external world (e.g., actual sights or sounds) in a distorted way. An *hallucination*, by contrast, is a perception for which there are no corresponding sensory stimuli—e.g., hearing noises in a perfectly quiet place, or seeing things that are not there.

it orally have shown milder mental disturbances. It is difficult, if not impossible, to predict the response of a given individual to this drug, especially where the size of the dose is not known.

How Does PCP Affect the Body and the Brain?

It has been found that PCP slightly increases pulse rate and rate of breathing. Increases in blood pressure are more noticeable. Other physical effects that can occur include loss of muscular coordination, dizziness, unsteady gait, nausea, and vomiting.

PCP's action on the brain has been the subject of much research but is still not well understood. It is thought that PCP acts primarily on the sensory cortex, brain-stem, and thalamus. Animal studies have shown that PCP can alter the amount of certain naturally occurring chemicals that are present in the brain. Some years ago, researchers investigated its potential for the relief of anxiety and for use as an anesthetic in some types of surgery. Other researchers used PCP to produce symptoms similar to those of schizophrenia in an attempt to gain a greater understanding of this form of mental illness. However, the drug was never marketed for these purposes or for any use with humans.

Is PCP Much Like LSD or Mescaline?

Users of phencyclidine, LSD, or mescaline may have feelings of depersonalization, distortions of body image, feelings of isolation, drowsiness and apathy, dream-like experiences while awake, or a high feeling much like drunkenness. However, a person who takes a high enough dose of phencyclidine may experience some additional effects. Muscular coordination, ability to pay attention, and ability to think abstractly and sequentially may be impaired. Emotional

reactions may be lacking or inappropriate. Often, there will be negative and hostile feelings. Differences between LSD and phencyclidine are apparent in the way a small group of chronic schizophrenic patients reacted to the two drugs. Such patients are generally quite resistant to the effects of LSD; with phencyclidine, their condition seemed to be made worse for a time.

One explanation that is offered for the way PCP affects the brain is that it blocks the physiological processes that enable a person to sort out stimuli in his environment, to choose to pay attention to some things and ignore others, and to attach the correct interpretation to the actions or statements of others. This could account for the hostility and confusion that can appear in the drug state. Some researchers consider this effect to be similar to that associated with sensory deprivation. It would be as though PCP put the user "in solitary." Others, however, feel that this view is wrong. One experimental study has even shown that the effects of PCP are diminished if the user is isolated from various stimuli. Sensory deprivation (without PCP) has produced temporary improvement in some schizophrenic patients.

Can PCP Do Permanent Damage?

The studies we have examined show the effects of PCP generally passing off in a matter of hours. Patients operated on under PCP remained awake but felt no pain and later could not remember the operation. They seemed euphoric and disoriented for 3 to 18 hours afterward. Much, however, depends on dose, and on the reaction of the individual. In this same study, about 15% of the patients had psychotic confusion that continued for 12 to 72 hours, and in one case a psychotic reaction lasted four days. After these periods of time, however, all patients seemed to return to their usual mental state. Even schizophrenic patients who have

been adversely affected by PCP will apparently return to the state they were in before taking the drug.

There are no indications in the literature that permanent damage occurs. However, it is now known that hallucinogens as a group present certain hazards, and it would seem reasonable to ask whether some or all of these might apply to PCP. One of these is the flash-back—a repetition of something like the drug experience occurring at a later time when no more of the drug has been taken. Another is the possibility of inappropriate or dangerous behavior (e.g., reckless driving or assault) while a person is in a disoriented and possibly hostile state. A third is the fact that other hallucinogens seem to be able to push some unstable people over the brink, into long-term mental illness. If this can happen with LSD and other hallucinogens, is it possible with PCP? Also, can any of these substances damage the mental health of a user with no previous history of mental or emotional disorder? And can any of these substances affect an unborn child, if a user is pregnant, or cause chromosomal changes? Unfortunately, we do not yet know the answers to these questions.

Is PCP Capable of Producing Drug Dependence?

Again, research studies as yet provide no answers. All we can do is point to what is known about other hallucinogens. These do not seem to produce physical dependence. However, there seem to be people who enjoy the escape from reality that is provided by any mind-altering drug. These people may tend to return to this again and again.

Can PCP Cause Death by Poisoning?

This same question is often asked about other hallucinogens. The answer, in the case of most of these, seems to be No. However, a mushroom of the *Psilocybe* family is reported to have caused the death of a child, and the evidence concern-

ing MDA is not clear. (Nevertheless, MDA preparations have recently been implicated in a number of deaths.) Death from nutmeg poisoning has been reported but is extremely rare. To our knowledge, there have been no poisoning deaths attributable to PCP.

PCP in Ontario

Obviously, there is no way of telling, on casual inspection, whether a particular tablet or capsule a young person has bought on the street contains—or does not contain—phencyclidine. However, one additional piece of information from the A.R.F. laboratory might be offered as a sort of “helpful hint.” There is some reason to believe that PCP may most often be presented as mescaline—a drug which may itself be rare in Ontario. Of 37 samples brought to our laboratory that were alleged to be mescaline, not one was as described. But 26 of them did contain PCP, either alone or in combination with LSD.

PHENCYCLIDINE De février à octobre 1971, 50 des échantillons
(*PCP*): de drogues illégales qui furent apportés à la
DROGUE DE LA Addiction Research Foundation pour analyse,
RUE EN contenaient de la phencyclidine ou une com-
LABORATOIRE binaison de phencyclidine et d'autre drogue.
Habituellement, cette drogue avait été décrite
par des vendeurs comme étant autre chose,
bien souvent de la mescaline. Dans cet article,
les auteurs discutent quelques-uns des effets
caractéristiques et des dangers possibles de la
PCP, une substance à laquelle il est difficile
de prédire la réaction d'un individu en par-
ticulier. En général, toutefois, on peut dire
que la phencyclidine, en comparaison avec le
LSD, peut imiter un plus grand nombre des
symptômes associés avec la schizophrénie.

Middle-aged Ethyl-heads have Teenagers Worried

by Wayne A. Howell

Taking his cue from the celebrated Le Dain Commission, 17-year-old Paul Goodman has organized a Committee of Concerned Teenagers. The committee will arouse civic-minded teenagers to the dangers of drug use among middle-agers. I found Paul organizing his campaign in a cluttered Yorkville apartment.

"Why have you started this campaign?" I asked him.

"The use of drugs by our middle-agers is assuming frightening proportions. We have statistics to show that 80 per cent of them have dabbled in beer and liquor; 3.5 per cent of them are confirmed ethyl-freaks. There are over 700,000 ethyl-heads right in Metropolitan Toronto!" he said as he cleaned the crud out of his favorite hashish pipe.

"What happens when a middle-ager becomes an ethyl-head?" I asked.

"He loses his competitive drive, develops an alien set of values, drops out of society, and lives in a communal drug pad called 'skid row,' " he said.

"What do we know about the drugs used by middle-agers?" I asked.

Dr. Howell is an Ottawa physician and free-lance writer. This article first appeared in *The Toronto Daily Star*, August 23, 1971. It is used here with the kind permission of the author, who assures us that the name used in this delightful little satire is not intended to refer to any person living or dead, teen-aged or middle-aged.

Editor

"There is an active ingredient common to all. Scientists have found they all contain a simple alcohol called 'ethanol,' " he said.

"How is this drug used?" I asked.

"The soft drugs are consumed straight. The hard drugs are usually mixed with water or soda. The confirmed ethyl-head drinks his hard stuff 'neat,' " he explained.

"These terms are confusing," I remarked.

"The users have their own special jargon. For instance, a trip is called 'getting bombed,' or 'tying one on.' A bad trip is called 'barfing-out.' "

"How is the drug obtained?" I asked.

"There are domestic and foreign sources. An ethyl-freak may obtain a 'mickey,' which is a small curved flask designed to be concealed on the body, for about \$3."

"I've heard that in many cases an ethyl-head may not know what he is getting," I said.

"This is especially true in Ontario where the user is not allowed to see the bottle before purchase. Users call a bad product 'rot-gut' and the users put some Canadian grape ferments in this category," he said.

"What are the dangers of ethyl-use?" I asked.

"Bad trips lead to 'barfing-out.' Users also refer to a delayed reaction which they describe in their colorful jargon as a 'hangover,' " he said.

"Are there long-term effects?" I asked.

“Long-term use causes gastritis, cirrhosis of the liver, and a toxic psychosis where the user sees pink elephants,” he said.

“Pink elephants!”

“There is still a lot we don’t know,” he said, offering me a drag on his hookah.

“Given these dangers, why do you think middle-agers use this drug?” I asked.

“Middle-agers are frightened and insecure. We teenagers have created a world they don’t understand. I think in many ways their drug taking is a form of rebellion against us because we control the society in which they live. Of course, peer group pressure is very important. Many go along to be part of the crowd,” he said.

“Could you give me an example of how they use ethanol?” I asked.

“We find that ethyl-heads tend to congregate in small groups for the purpose of drug use. As they consume the drug they may listen to music, talk in an increasingly garrulous fashion, and indulge in sexual flirtations,” he said.

“Do they have a name for these gatherings?” I asked.

“They call them ‘cocktail parties,’ ” he said.

A Note on Solvent Sniffing in Toronto

by Mora Gregg

Solvent sniffing is a problem that is often overlooked by people in the field of drug abuse who do not work directly with children. It is often overshadowed by problems we regard as more serious such as speed and heroin use. However, the youth worker who encounters solvent sniffing among his clients regards the problem as one of the most difficult and frustrating he must deal with. In order to find out more about the nature of the problem in Toronto, we brought together five youth workers, a therapist, and a community consultant employed by various agencies to share their impressions with us. The following is a summary of their observations, frustrations, and suggestions for solving the problem.

The youth workers at the talk session represented three neighborhoods in the city—Parkdale, Bloor-Dufferin, and Regent Park. They agreed that the most readily available and most commonly used solvent is nail-polish remover. There are several reasons for this.

Although the police try to discourage solvent sniffing by confiscating bottles, by picking up the under-16's for juvenile

Mora Gregg is an Editorial Assistant in the Creative Group of the Addiction Research Foundation. She wishes to thank the following people who participated in the taped discussion: Jesse Dean, 12 Madison Project; Lesley Forrester, Y.M.C.A.; Marnie Marley, A.R.F. Central Toronto Branch; Heather Matthews, The Place; Kathleen E. Michael, A.R.F. Central Toronto Branch; Barry Saxton, Community Guardian, Regent Park; Norman Smith, Parkdale Drop-in; and Harriett Weidmann of the Creative Group who organized the discussion.

delinquency and the over-16's on some charge such as vagrancy, it is not clearly illegal to sniff nail-polish remover.

Nail-polish remover is inexpensive, even when it is bought. Usually, it is stolen. Although some chain stores have been persuaded to take it off the open shelves and keep it behind the counter, not all have done so. Some small stores also have not removed solvents from their shelves. However, many other small businesses have been willing to do this.

The workers feel that kids would prefer to use other drugs if they had the money. Some would turn to alcoholic beverages; others would use marihuana, hashish, speed, or LSD to emulate some older, richer kids. Some chronic sniffers in their late teens or early twenties have been known to use these other drugs in addition to solvents.

Who Sniffs Solvents?

The workers noted that generally there are three distinct groups of sniffers. The first group usually consists of people in their early teens, although a few sniffers as young as eight have been found. Much of their sniffing is occasional and experimental in nature. The second and smaller group, between the ages of 15 and 17, make heavy use of solvents and are a greater cause for concern to the workers. The third group, which is very small, consists of people in their early twenties whose use of solvents is chronic and long-term.

The family life of solvent sniffers is poor in general. However, as the youth workers pointed out, this poor family life is far from exceptional in these neighborhoods. Problems encountered in the families include unemployment, poverty, alcoholism, and absence of one parent. One worker stated that the family life of most chronic sniffers can only be described as "chaotic."

Sniffers generally seem to have low self-esteem. This reflects the fact that in the eyes of their peers who do not use solvents, the sniffers are of very low status indeed. They are often openly ridiculed: their peers don't think highly of the solvent "stone."

A therapist who works with a group of sniffers commented that she has found alcoholism in the home to be a very common problem. In effect, some children are imitating their parents in that they turn to a chemical to achieve a temporary happiness. These children, she feels, have never really learned how to be happy, how to trust others, or how to relate to others.

Solvent Sniffing in Affluent Areas?

One possible explanation for why there appears to be little sniffing in more affluent areas is economic. Middle-class children have more money and therefore, access to what they would consider "safer" drugs such as alcohol and cannabis. Middle-class kids are impressed by the fact that solvents may cause physical damage. Furthermore, as mentioned above, the other drugs have much more prestige than solvents.

On the other hand, one might speculate that sniffing among middle-class kids may be more common than available evidence indicates. The problem, like that of the housewife-alcoholic, may be kept in the family. A child may, for a time, even hide his habit from his parents. When a problem is discovered, the parents may send the child to a psychiatrist in private practice. Consequently, he may never come to the attention of the social agencies or of the police. He may never enter the statistics.

Behavior when Stoned

Generally, kids do not sniff alone. Companionship is desirable to prevent each other from freaking out. Some sit quietly in a state of sleepy inactivity. Others become very energetic and engage in activities such as floor hockey in spite of their impaired coordination. They appear to be oblivious to injuries and will come back for more punishment when a "straight" kid would not. Sometimes, sniffers become very aggressive and engage in fighting and vandalism.

Youngsters, when stoned, tend to get into "hassles" among themselves and will react with intense anger to real or imagined slights. Often a sniffer will respond aggressively to a bystander or kibitzer—whether peer or respected adult—whom he feels intends to interfere with his sniffing. One youth worker recalled an incident when a young sniffer behaved very pugnaciously toward a minister who worked in a drop-in centre. The following day he apologized to the minister.

Workers have reported that kids will sniff in preparation for a fight with a rival gang. Apparently, they sniff on these occasions to get up their courage and to numb their sense of pain in preparation for the blows to come. Since such battles rarely materialize, sniffing in preparation would appear to be mainly a show of bravado.

What to Do?

Youth workers find it very frustrating trying to provide alternative activities to substitute for solvent sniffing, particularly for the heavy sniffers in their middle teens. Most activities provided in a community are geared to a younger age group. Furthermore, when activities such as drop-ins, floor

hockey, and dances are available, the presence of sniffers is often too disruptive to tolerate.

The Sniffer and the Community

Workers in the drop-ins and on the street find they just don't have the time required to devote consistent attention to the sniffers. After all, the youth worker is there to serve the "community of youngsters," and often his job is most effectively accomplished at the expense of the sniffers who form a small minority group.

The workers feel that pulling the sniffers out of the community for special treatment is not the answer. In fact, if properly handled, the influence of their peers can be very constructive. The best answer, they feel, is to provide neighborhoods which have a high incidence of solvent sniffing with a youth worker whose sole task is to work with solvent sniffers.

A Consistent, Caring Adult

This youth worker could do quite a number of things. He could encourage sniffers to set up their own therapy groups, and he could act as liaison between the kids and interested therapists in social agencies. He could advise and intervene when a sniffer has a run-in with the law, his school, or his family. The worker could encourage interested and concerned adults in the neighborhood to become involved with sniffers. Finally, a youth worker assigned to solvent sniffers would have more time than other workers to spend with the sniffers—talking, listening, admonishing, encouraging. This is what many of these children need more than anything—a patient, consistent, caring adult.

*COMMENTAIRE
SUR LE
RENIFLEMENT
DE SOLVANTS
A TORONTO*

Cet article est un résumé d'une discussion entre cinq assistants à la jeunesse, un conseiller social et un thérapeute que nous avons rassemblés pour mettre en commun leurs connaissances sur le reniflement de solvants à Toronto. Les assistants représentent trois voisinages à bas revenu où le reniflement de solvants est prédominant chez les adolescents. Ces enfants reniflent du décapant à poli à ongles; la vie de famille de bon nombre entre eux est médiocre; beaucoup d'entre eux ont très peu respect d'eux-mêmes et éprouvent beaucoup de difficultés à entrer en contact avec les autres. Le reniflement de solvants ne semble pas être aussi prédominant chez les enfants de classe moyenne, soit qu'ils peuvent se payer d'autres drogues ou que leur usage de solvants soit bien caché. Ces assistants suggèrent qu'un assistant à la jeunesse soit désigné aux endroits où l'usage de solvants est élevé pour faire face aux renifleurs de solvants et à leurs problèmes.

The Forgotten Children

A paperback book by R. Margaret Cork

This is the second printing of a book about 115 children who were interviewed by Margaret Cork, the social worker who heads the Addiction Research Foundation's Youth Counseling Service in Toronto. All of these children came from the homes of alcoholics, and most of them have disturbing stories to tell. Miss Cork says these children need help. She believes they should have it, whether or not their parents are willing to accept help for themselves. The fact that Ontario is estimated to have some 120,000 alcoholics, many of whom are parents, points up the magnitude of the problem. 95 cents.

The Pursuit of Intoxication

A new paperback book by Andrew I. Malcolm

Dr. Malcolm has been a staff psychiatrist with the Addiction Research Foundation for nine years. His book examines the many reasons why people have used and continue to use the psychoactive drugs. These reasons are examined under five main headings: Religion, Medicine, Endurance, Extinction, and Recreation. The book not only has something to say about all drugs in current use; it also attempts to place the use of these drugs in historical perspective. \$2.50.

Drugs, Society, and Personal Choice

A new paperback book by
Harold Kalant and Oriana Josseau Kalant

This is a book designed to help people—as individuals, as family members, and as policymakers—to arrive at fully informed, balanced, reasonable decisions about drugs. Many scientists today are concerned that their work should contribute to this process. Dr. Harold Kalant is Associate Director of Research and his wife, Dr. Oriana Kalant, is a Research Scientist at the Addiction Research Foundation. They wish to provide through this book data and ways of dealing with data that will assist responsible citizens in achieving a perspective that can lead to an appropriate decision. \$1.95.

The Forgotten Children and *Drugs, Society, and Personal Choice* are published by PaperJacks, a division of General Publishing Company, 30 Lesmill Road, Don Mills, Ontario in association with the Addiction Research Foundation of Ontario. *The Pursuit of Intoxication* is published by the Addiction Research Foundation and distributed by PaperJacks. Copies of these books are available at book stores and from General Publishing. They may also be obtained by writing to the Addiction Research Foundation, 33 Russell Street, Toronto 179, Ontario. When ordering any of these books from the Foundation, please enclose with your order \$2.00 for *Drugs, Society, and Personal Choice*, \$1.00 for *The Forgotten Children*, or \$2.50 for *The Pursuit of Intoxication*.

The Addiction Research Foundation of Ontario is an official government agency established in 1949 and financed by annual provincial grants. Its purpose is to learn more about the effects of alcohol and other drugs and to develop improved ways of preventing and managing alcoholism and drug dependence. Helpful information about these matters is available from A.R.F. offices located in:

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The Addiction Research Foundation was established in 1949 by an act of the Ontario Legislature and is financed mainly by an annual government grant. Its objects are:

- to conduct and promote research in alcoholism and other forms of addiction; and
- to conduct, direct, and promote programs for:
 - the treatment and rehabilitation of alcoholics and other addicts,
 - experimentation in methods of treating and rehabilitating alcoholics and other addicts, and
 - the dissemination of information respecting the recognition, prevention, and treatment of alcoholism and other forms of addiction.

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